METHOD

Case Identification

Unintentional drowning deaths of 0-5 year old children that occurred between 1989 and 2001 were identified and verified by searching electronic data collected and stored by the Coronial Services Centre (CSC) and the Monash University Accident Research Centre (MUARC).

Multiple data sources were utilised to overcome the possibility of missing cases. These case identification methods are outlined below.

1. Keyword search conducted on the TOPIC database, which contains electronically stored police report summaries and Coroner's findings.

2. Incident code search of the State Coroner's Office (SCO) Local Case Management System (LCMS) where incident code equalled “DRW” (drowning) for period 1989 – 2001 (inclusive).


4. Search of the Victorian Coronial Facilitation System (VCFS) provided by MUARC, verified using the publications titled *Unnatural Deaths: Collated from the findings of the State Coroner*.

5. Search of the National Coroners Information System (NCIS) for all deaths where the mechanism of death = threats to breathing, drowning and immersion and the object involved in the death = building, building component or fitting, bathtub for deaths from July 2000 onwards.

These searches involved:

1. **Topic**

   Electronic versions of police report summaries (known as “Form 83 circumstances text”) and Coroner's findings were searched using keywords such as bath; bathtub; drown; drowned and drowning. These documents are stored on a database called “TOPIC”, which allows for multiple term searching. TOPIC contains data from 1989 onwards. The reports are not available for all cases, particularly deaths that occurred in rural jurisdictions between 1989 and 1999.

2. **State Coroner's Office Local Case Management System (SCO LCMS)**

   When a death is reported to the Coroner, it is entered onto the SCO LCMS, which dates back to 1989. At the time of being entered, a code is assigned to the case that relates to the type of incident that has occurred. One such incident code is “DRW” (drowning). All cases coded as drowning from 1989-2001 were selected and police report summaries obtained for each case. These summaries were reviewed to identify cases where the drowning incident occurred in a bathtub and the deceased was aged between zero and five years.

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5 TOPIC is maintained by the Victorian Institute of Forensic Medicine (VIFM) for use by Coronial Services Centre staff.
3. Structured Query Language (SQL)
An SQL search was conducted on the SCO LCMS to identify all cases that were coded as “drowning”. This was done using the "manner of death" codes reclassified by a Research Officer at the Victorian Institute of Forensic Medicine (VIFM) for the period 1989 onwards.

4. Victorian Coronial Facilitation System (VCFS)
The Monash University Accident Research Centre (MUARC) provided the SCO with a copy of the VCFS. The VCFS is a database containing information on all closed cases (cases where the Coroner had made a finding) between July 1989 and June 1995. This database was collated and coded by the Caseflow Analysis Section of the Courts and Tribunals Division of the Department of Justice (Stathakis and Scott, 1999).

This information was also printed as five annual report like publications titled Unnatural Deaths: Collated from the findings of the State Coroner. These publications contained tables of data listing text descriptions and other codes by manner of death. Each death in the drowning section was reviewed in order to identify relevant cases.

5. National Coroner's Information System (NCIS)
Drowning deaths of children aged 0-5 years in bathtubs that occurred between July 2000 and December 2001 in Victoria were extracted from the NCIS. The NCIS is a national database that stores all deaths reported to the Coroner in Australia. Victorian cases were identified for the purposes of verification.

**Data Collection**

In all 25 cases the Coroner had completed the investigation and made a finding. This meant that all the information collected by the police during the death investigation was available in the file. Each file generally contained the following information:

- initial police report of death to the Coroner (Victoria Police Form 83);
- post-mortem examination reports:
  - autopsy report; and
  - toxicology report.
- inquest brief:
  - investigating police officer's summary of events from statements;
  - witness statements; and
  - photographs.
- Coroner's finding.

A list of data items for collection from each case was compiled from previous research into the area of drowning, and from a review of the cases. These data items were entered into a Microsoft Excel Spreadsheet and are listed in Table 2.
TABLE 3
List of data items

<table>
<thead>
<tr>
<th>Name</th>
<th>Carer/s Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Status (open/completed)</td>
<td>Carer / Deceased Relationship</td>
</tr>
<tr>
<td>Deceased’s Gender</td>
<td>Carer/s Age</td>
</tr>
<tr>
<td>Deceased’s Age (years and months)</td>
<td>Carer/s Mental or Physical Illness</td>
</tr>
<tr>
<td>Deceased’s Mental of Physical Illness</td>
<td>Season</td>
</tr>
<tr>
<td>Date, Day and Time of Incident</td>
<td>Postcode</td>
</tr>
<tr>
<td>Suburb of Incident</td>
<td>Carer/s Location in Relation to the Deceased</td>
</tr>
<tr>
<td>Location (rural or urban)</td>
<td>Time Period Estimated by Carer/s since Deceased Last Seen Alive</td>
</tr>
<tr>
<td>Deceased's Activity According to the Carer/s at the Time of the Incident</td>
<td>Presence of a Distraction to Supervision</td>
</tr>
<tr>
<td>Carer/s Activity at the Time of the Incident</td>
<td>Evidence of Carer Supervision</td>
</tr>
<tr>
<td>Type of Bath</td>
<td>Carer Supervision Codes (attention, proximity, continuity)</td>
</tr>
<tr>
<td>Was the Child Bathing at the time of the Incident</td>
<td>Presence of other children in the Bath Prior to and at the Time of the Incident</td>
</tr>
<tr>
<td>Water Level</td>
<td>Age of Other Children in the Bath</td>
</tr>
<tr>
<td>Number of Adults Present at the Time of the Incident</td>
<td>Number of Children Present at the Time of the Incident</td>
</tr>
<tr>
<td>Resuscitation Attempts and by Who</td>
<td>Child’s Behaviour Around Water</td>
</tr>
<tr>
<td>Contributing Factors</td>
<td>Presence of Another Adult to Supervise the Child</td>
</tr>
</tbody>
</table>

A second review of the cases was undertaken for the purposes of data entry. Some data items could not be completed for all cases, either because the information was not contained in the coronial file or the data item was not relevant to the particular case.

Data Analysis

Quantitative

The Auto Filter function on Microsoft Excel was utilised to calculate the frequencies of the following data items:

- number of deaths per year (1989 – 2001);
- time of day (3 hour blocks);
- day of week;
- time of year (seasonal);
- month of year;
- location (urban / rural);
- activity (shared bathing, bathing alone, not bathing); and
- carer supervision (using hierarchy model of Saluja et al., 2004)

In relation to carer supervision, the three dimensions of attention, proximity and continuity were coded on a case by case basis. Attention was coded according to the location and activity of the carer, that is if the carer was located in another room from the child attention was coded as "auditory". Where there was evidence that the carer was listening out for the child, the case was coded as "auditory focal". If there was evidence that the carer was engaged in other activities such as cooking, vacuuming or
watching televisions, the case was coded as "auditory peripheral". Proximity was coded according to the location of the carer. If the carer was located in another room of the house the case was coded as "beyond reach, nearby". If the carer was located outside the house the case was coded as "beyond reach, distant". Continuity was coded according to carer activity. In cases where the carer left the bathroom to prepare the child's clothes and returned immediately to the bathroom, the case was coded as "intermittent". Where the carer left the bathroom to engage in other activities such as hanging out the washing, continuity was coded as "absent".

**Qualitative**

Each case was allocated to one of three groups according to the activity of the child at the time of the incident:

- shared bathing;
- bathing alone; and
- not bathing.

Within the two bathing activity groups, each case was further allocated to one of two carer supervision categories depending on the level of carer supervision immediately prior to the incident. Level 1 was considered to be the lower of the two levels of supervision. This was defined as situations where the carer consciously engaged in non-bath related activities after the child was placed in the bath. Non-bath related activities included: house work, such as cleaning, washing clothes or cooking; watching television; and entertaining guests. Level 2 Supervision was considered to be the higher of the two levels of supervision. This level of supervision was defined as situations where the carer engaged in bathing related activities after the child was placed in the bathtub. This included, preparing the child's clothes or tending to other children who had been taken out of the bath. Similarities and differences amongst the cases in each category and between the cases in each category were examined in order to develop a typology or set of common factors.

**Limitations**

**Data Source**

The data source utilised in the current study consisted of information submitted to the State Coroner's Office (SCO) for the purposes of death investigation. As the electronic system of data storage and retrieval is based on case management needs, it has limitations for research purposes. In particular information on ethnicity and socio-economic status is not routinely collected, as it is generally not deemed relevant to the coronial investigation.

**Electronic Case Coding and Identification**

There are a number of limitations in relation to case identification using the electronic coronial databases. Deaths that occur in rural Victoria are often handled by the local Magistrate/s, who also act as Coroners. Once the case is completed, that is the Coroner has made a finding, the documents are sent to Melbourne and stored at the Coronial Services Centre (CSC). The electronic textual information (police summary

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6 The supervision levels were used for research purposes only. Adequate supervision should be regarded as within arms reach for children under five years of age and physical contact for children under one year.
of circumstances and Coroner's findings) for cases completed in rural Victoria prior to 2000 are not all stored on the SCO LCMS. As a result a keyword search using TOPIC would miss these cases.

The accuracy of textual information is also problematic, particularly the police Form 83 circumstances text. The Form 83 is required to be submitted to the Coroner within 24 hours of the death occurring in order to inform the forensic procedures and further investigation. Often information is scarce in the first 24 hours of the death and it is not until the investigation is almost complete that the events leading to the death are documented with any accuracy. This process can take days or even months. From a research perspective this information could be interpreted only as a guide.

Coding of the deaths is also not designed with research in mind. A death is classified using incident type codes, for example a drowning death of a young child could be coded as either "DRW" (drowning death) or "INF" (death of an infant). These codes are allocated to cases when they are first reported to the SCO, and are not updated as more details are known about the case. Therefore, the code used may become inappropriate.
RESULTS

Trend Over Time

The number of drowning deaths of 0-5 year old children in bathtubs between 1989 and 2001 is shown in Figure 2. In total there were 25 deaths with an average of 1.9 deaths per year. It can be seen that there was a peak every four to five years: in 1990, 1995 and 1999.

![Figure 2](image2.jpg)

**FIGURE 2**
Frequency of drowning deaths in bathtubs per year

Age & Gender

The age and gender distribution is illustrated in Figure 3. It can be seen that 17 of the 25 (68%) children were male and 19 of the 25 (76%) children were aged 24 months (or 2 years) and under. The median age of the group was 15 months and the mode was 16 months.

![Figure 3](image3.jpg)

**FIGURE 3**
Number of deaths by age and gender
**Time of Day**

Seventeen of the 25 (68%) drowning incidents occurred in the afternoon, between 12:00 pm and 5:59 pm.

![Bar chart showing frequency of deaths by time of day.](image)

**FIGURE 4**
Frequency of deaths by time of day

**Day of Week**

Nineteen of the 25 (76%) incidents occurred on a weekday, the large majority between Tuesday and Thursday.

![Bar chart showing frequency of deaths by day of week.](image)

**FIGURE 5**
Frequency of deaths by day of week
**Time of Year**

Forty-four percent of the incidents occurred during the Winter months of June to August. This was mostly a result of the large number of deaths that occurred in the month of August, See Figure 7.

![Pie chart showing percentage of deaths by time of year](image)

**FIGURE 6**
Percentage of deaths by time of year

**Month of Year**

The largest number of drowning deaths, n=7 (28%), occurred in August.

![Bar chart showing frequency of deaths by month of year](image)

**FIGURE 7**
Frequency of deaths by month of year
Location

Sixteen of the 25 (64%) incidents occurred at an urban location, many in metropolitan Melbourne. With the exception of one, every incident occurred in the child’s own home. In every case, the drowning occurred in a standard size bath.

Figure 8
Location of drowning incident

Child Activity

In 22 of the 25 (88%) cases, the child was bathing when the incident occurred. In all of these cases the carer was absent from the bathroom at the time. In 14 of the 22 (64%) cases, the child was bathing with at least one other child and in the remaining eight (36%) cases, the child was bathing on their own.

Figure 9
Presence and number of children bathing with the deceased
In three of the 25 cases the child was not bathing at the time of the incident. In one of these cases the bath was being filled in preparation for bathing and in the other two cases water had been left from a sibling’s bath. In all three cases the child was left unsupervised by their carer, who assumed that the child was happily playing elsewhere in the house.

**Carer Supervision**

The overall theme among the drowning incidents was that carer supervision was inadequate immediately prior to the incident. The Royal Life Saving Society Australia (RLSSA), in their "Keep Watch" campaign, define adequate supervision as:

> Supervision means your child is being continually watched by you or an appropriate adult. Supervision should be constant, not the occasional glance whilst you read a book or relax. Regardless of what you are doing, always keep watch when children are around the water. Take your child with you whenever you leave the swimming pool or bathtub. Never under any circumstances leave them alone.\(^7\)

The adequacy of carer supervision was also assessed using Saluja et al.'s (2004) dimensions of attention, proximity and continuity. Using this model it was found that the most common pattern amongst the cases (n=13, 52%) was that carer's attention was "auditory", proximity was "beyond reach, nearby" and continuity was "intermittent". There were no incidents where the child was under constant visual supervision by their carer immediately prior to the incident.

**TABLE 4**

Caregiver supervision as proposed by Saluja et al. (2004)

<table>
<thead>
<tr>
<th></th>
<th>Attention</th>
<th>Proximity</th>
<th>Continuity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Engagement / Interaction with child</td>
<td>0</td>
<td>Touching</td>
</tr>
<tr>
<td>Visual</td>
<td>0</td>
<td>Within reach</td>
<td>0</td>
</tr>
<tr>
<td>- Focal</td>
<td>(0)</td>
<td>(0)</td>
<td></td>
</tr>
<tr>
<td>- Peripheral</td>
<td>(0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auditory</td>
<td>25</td>
<td>Beyond reach</td>
<td>25</td>
</tr>
<tr>
<td>- Focal</td>
<td>(10)</td>
<td>- Nearby</td>
<td>(23)</td>
</tr>
<tr>
<td>- Peripheral</td>
<td>(15)</td>
<td>- Distant</td>
<td>(2)</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>

The issue of carer supervision was examined in more detail according to whether the child was bathing at the time of drowning incident and whether they were bathing alone or with other children. In the cases where the child was bathing at the time of the incident, the level of carer supervision was assessed according to two levels. Level 1 was considered to be the lower of the two levels of supervision. This was defined as situations where the carer consciously engaged in non-bath related activities after the child was placed in the bath. Non-bathing related activities included: housework, such as cleaning, washing or cooking; watching television; and entertaining guests.

Level 2 supervision was considered to be the higher of the two levels of supervision, however it must be noted that this level of supervision was not considered adequate as defined by the RLSSA. This level of supervision was defined as situations where the

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\(^7\) Source: RLSSA, Victoria Branch. *Keep Watch* brochure.
carer engaged in bathing related activities after the child was placed in the bathtub. This included, preparing the child's clothes or tending to other children who had been taken out of the bath.

For the purposes of data analysis and presentation of results, the cases were divided into three groups: shared bathing; bathing alone; and not bathing. In 22 of the 25 cases the child was bathing at the time of the drowning incident. Fourteen of these 22 incidents (64%) occurred in the context of shared bathing.

**Shared Bathing**

**Supervision Level 1**

In 10 (seven male and three female) of the 22 (45%) deaths where the child’s activity was bathing, the deceased was sharing a bath and carer supervision was categorised as level 1. In all cases the deceased was the youngest child in the bath and in the family, with the average age being 15 months. In eight of the ten cases, the other child in the bath was an older brother, with the average age being 30 months (or 2.5 years) and the average age difference being 17 months. In all ten cases, all children were aged five years and under.

In relation to the carers of these children, six were female and four were male. Where information was available for the female carers (n=5), all of whom were the child’s mother, the average age was 25 years. Where information was available for the male carers (n=3) the average age was 27 years. Three of the four male carers were the child’s father.

Where information was available (n=9/10), the carer reported leaving the deceased unsupervised for between two and ten minutes. It is difficult to assess these time periods with any accuracy, as it may be likely that carers could have underestimated the amount of time the child was left unattended. Any underestimate may have been unintentional, however it may also have been in fear of blame from others for the child’s death. Despite this, it is well documented that drowning can occur within two minutes of immersion.

In half of these incidents (n=5/10), the carer left the deceased in the bathtub in order to engage in home duties.

... I ran a bath and placed both DECEASED and BROTHER (3 years) in the bath. ... After placing both children in the bath I walked to the lounge room and began vacuuming. I had been vacuuming for approximately five minutes, no longer, when I returned to the bath to check on the children. [Mother's statement - Case 2567/1991] 16 months female

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After a few minutes, I left BROTHER and DECEASED to play and get clean together and I went to the back yard to hang the washing on the line. [Mother’s statement – 2132/1994] 10 months female

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I put DECEASED in the bath and then I went into the main bedroom and started making the bed. DEFACTO HUSBAND came into the bedroom and I asked him to straighten the bed sheet on his side. He then got dressed and I was folding the clothes. DEFACTO went into
the bathroom, the next thing I heard was this god almighty scream.  
[Mother’s statement – 3764/1995] 10 months male

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I went into the bathroom and saw all three kids in the bath. ... They were all sitting upright and they were happy and playing with some of the toys. I was happy that the kids were fine and I went back to the kitchen to fix up tea. [Carer's statement - Case 0907/1997] ~3 years female (35 months)

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I then went out of the bathroom and into the lounge room to get my cup of coffee which I had left on the mantle-piece. I then went directly back into the bathroom. I checked on the boys, and they were still seated in the bath playing. I left immediately upon seeing they were ok and went into the laundry to put a load of washing on. [Mother's statement - Case 1549/1997] 11 months male

In three of the six incidents outlined above (case numbers 2134/94, 0907/97 & 1549/97), the Coroner stated in the finding that the carer contributed to the child’s death as a result of their inadequate level of supervision.

In the remaining five of the ten incidents the carer left the bathroom for reasons unrelated to home duties. In three of these five cases the Coroner made a finding of contribution against the carer for the child’s death (case numbers 4101/92, 0346/95 & 0800/99).

MOTHER ran a bath, put the boys in, asked me to take care of them and she went and laid down on the couch in the lounge room. I went into the bathroom to watch the boys. BROTHER (2 years) sat in the bath unassisted and I put DECEASED in a blow up “floatee” device. ... I made sure both boys were right in the bath, they seemed content, so I left the bathroom and walked into the lounge to speak to some relatives. During the course of this conversation, I went back and forth into the bathroom on several occasions to check the boys. On the last occasion that I checked, I walked into the bathroom and observed DECEASED floating face down in the water and the “floatee” also floating. [Father’s statement – 4101/1992] 8 months male

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... I left the water running for a short time and put the plug in the bath so the kids could have a bit of a play in the water. ... I have then gone to my bedroom to get changed, the room being approximately 5 metres away from the bathroom. I have left the door of the bedroom and bathroom open enough so as to be able to hear my kids if they cried. When I left the kids in the bathroom, SISTER (2.5 years) was sitting at the western end of the bath (where the plug is situated) and DECEASED was lying on his back at the eastern end of the bath. The water level of the bath came up to DECEASED'S ears. I have done this on numerous other occasions with no problems whatsoever. ... I then

8 Note: as of 1 July 1999 Coroners in Victoria were no longer required to find that a person contributed to a death.
went to the bathroom to check on the kids. When I checked on the kids they were both playing in the water, just having fun. ... I then returned to my room to complete getting dressed. ... then I heard SISTER call out for me. I had probably been away from the bathroom for about 3-5 minutes at the extreme most. [Mother's statement - 0346/1995] 10 months male

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I would have been with the kids for about 10 minutes. I then had to go to the toilet, which is located right next to the bathroom. I never leave the children alone in the bath. On this occasion I couldn't wait to go to the toilet I had to go. I thought that because I was so close to the bathroom it would be alright. I would have been out of the room for about three or four minutes. I could hear both the kids splashing and laughing in the bath. About one or two minutes later everything went very quiet. I went from the toilet straight to the bath, I could see BROTHER but I couldn't see DECEASED. [Mother's statement - 2264/1995] 17 months male

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After tea SISTER (8 years) ran the bath and put DECEASED in the bath. DECEASED'S BROTHER (3 years) can get himself in the bath but he needs help to get undressed so I assume SISTER (8 years) helped him. While this was happening I cleaned up the kitchen. After this SISTER (10 years) went to her room to watch TV and SISTER (8 years) and I watched Optus in the lounge. ... During this I went down to the boys and told them off for splashing water out of the bath onto the floor. I could hear them laughing, having a great time splashing. The first time I checked them was about ten minutes after they initially got into the bath. After I told them off I went back to the lounge to watch TV. About ten minutes later I went back because the boys were playing up. ... I went to the bathroom and told them I was going to get them out and I was going to get their pyjamas. I left the bathroom, got their pyjamas, and went to the kitchen because the bell on the oven rang, as the apple pie was ready. ... [Father's statement - Case 0800/1999] 16 months male

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I put the two boys in the bath. ... At that point I felt the urge to go to the toilet, to use my bowels and although I was always aware that small children need supervision when in the bath, I needed to go and couldn't wait. The toilet was directly next to bathroom. I felt that I could go to the toilet and virtually watch the boys at the same time. I tried to be as quick as I could. I was in the toilet for a few minutes, but I can't say for exactly how long. [Mother's statement - Case 3726/2000] 13 months male

In nearly all the incidents (n=8/10) the carer became aware of the drowning incident during a routine check of the children (n=5) or on entry into the bathroom to remove the children from the bath.
I had been vacuuming for approximately five minutes, no longer, when I returned to the bath to check on the children. [Mother's statement - Case 2567/1991] 16 months female

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I finished hanging out the washing which only took another few minutes, as there were only a few items. I then came inside and went straight to the bathroom to check on BROTHER and DECEASED. When I got there, I was shocked to see DECEASED lying face down in the water. [Mother’s statement – 2132/1994] 10 months female

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I went back into the bedroom and gave DEFACTO WIFE a hand to make the bed and no longer than five minutes to ten minutes apart I went back in the bathroom to check the kids and I saw BROTHER (2.5 years) holding DECEASED in his arms towards his chest. [Father’s statement – 3764/1995] 10 months male

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On the last occasion that I checked, I walked into the bathroom and observed DECEASED floating face down in the water and the “floatee” also floating. [Father’s statement – 4101/1992] 8 months male

In only one case did the other child who was sharing the bath alert the carer to the drowning incident.

... I went to get the boys out of the bath. I'm sure that on my way down the hallway, I heard BROTHER yell out "Dad". That's when I found DECEASED lying face down in the bath. [Father's statement - Case 0800/1999] 16 months male

Supervision Level 2

Four of the 14 shared bathing incidents were classified as level 2 carer supervision. In all four cases the carer bathing the children left the deceased child in the bath unattended as they had removed the deceased’s sibling and were tending to them. In two of the four cases the deceased was the youngest child in the family.

MOTHER then placed a towel around her daughter (2 years) and then left the room, leaving DECEASED alone in the bath. MOTHER took her daughter to the kitchen where she then tended to DECEASED'S babyfood, which was heating on the stove [Investigating Police Member's Statement - Case 3224/1989] 10.5 months male

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I was at home with the rest of the children cleaning the house. As I did this my daughter (8 years) was bathing some of the other children. ... It is custom in our house that the older children help the younger ones. ... Whilst cleaning the house I kept an eye on the children being bathed. It was about five minutes after I had last checked them when I heard one of the children scream. I immediately ran into the bathroom to find DECEASED floating face up in the bath. [Mother's statement - 1275/1990] 1 year female
In the two remaining cases the deceased was the older child in the bath, both four years of age, who had been left in the bath while their mother was tending to the younger child. In both cases the child was prone to febrile convulsions / seizures⁹.

DECEASED'S Mother removed YOUNGER BROTHER from the bath and tended to him. When she returned DECEASED was found lying face down in the bath. ... The pathologist determined the cause of death to be immersion, he also made the comment 'it seems reasonable to conclude that DECEASED suffered a febrile convulsion and during the convulsion or after, lost consciousness and drowned'. [Coroner's finding - 2508/1996] 4 years male

Mother was bathing DECEASED and an 18 month old child in the household bath. Mother removed 18 month old and dried her off, then went to child's bedroom to get some clothes for the deceased. When the Mother returned to the bathroom she found the deceased under water. [police report summary of circumstances - Case 1608/2000) 4 years male

DECEASED'S motor skills and language skills were extremely limited. ... It is the opinion of the deceased's Doctor that the DECEASED probably suffered a severe convulsion, presumable one of the prolonged tonic clonic seizure to which he was prone. [Coroner's finding - Case 1608/2000] 4 years male

**Bathing Alone**

**Supervision Level 1**

In four of the 22 (18%) deaths, the child was bathing alone and carer supervision was categorised as level 1. In all four cases the deceased was a male and the average age was 22.5 months (or just under two years of age). On average this was eight and a half months older than the deceased children in the level 1 shared bathing scenarios.

In all four cases the carer was the mother of the deceased and their occupation was recorded as “home duties”. Carer age was only available in one of these four cases, which was reported as 20 years. Carers reported being absent from the bathroom for between two and 20 minutes, and in all cases the Coroner made a finding of contribution against the carer. The activity of the carer at the time of incident varied from watching television to taking clothes of the washing line, as reported below.

*I put DECEASED in the bath and then I started cleaning up around the house and was checking on DECEASED every five minutes. I then went out to get the washing off the line. The clothesline is situated right near the bathroom window. It took me about five minutes to take the clothes off the line. When I returned to the bathroom, I saw DECEASED floating face up in the bath. [Mother's statement - Case 4460/1989] 2.5 years male*

⁹ According to Blakiston's Gould Medical Dictionary, a febrile convulsion is defined as: *a generalized (sometimes focal) convulsive seizure accompanying fever, usually in children.*
MOTHER put child into bath and saw her Defacto husband off to work. MOTHER then sat in the lounge room to watch television. Child in the bath and could be heard to be splashing in the water. Some time later, approximately 5 minutes, the mother realised that there was no sound coming from the bathroom and went to investigate. Mother found the child face down in the water. [Investigation Police Member’s Summary of Circumstances – 2564/1990] 14 months male

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I put him in the bath. I went to collect his clothes and a towel. I put those in the bathroom with him and he was sitting up in the bath playing with his toys. The water wasn’t very deep. I suppose it would have come up to around his hips. I went into the kitchen and I rang my sister-in-law to see where my husband was as my husband and brother-in-law work together and she reminded me he was at the dentist. I then got a roll of frozen pastry out of the freezer and went in to check DECEASED and he was lying face down in the bath. [Mother’s statement – 2057/1991] 2.5 years male

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I took his clothes off and I put him in the bath. I washed DECEASED and watched him play in the water for about 20 minutes. ... I then decided to go into the lounge to fill out the deposit and withdrawal forms for the bank. I then got up and went into the lounge where I sat down on the lounge and quickly filled out the forms for the bank. This took me no more than a couple of minutes. The bathroom is no more than 5-6 metres from the place in the lounge where I was sitting. ... Whilst in the lounge I did not hear any splashing or any unusual noises coming from the bathroom. I then got up and returned to the bathroom where I found DECEASED lying on his side. [Mother’s statement – 1348/1994] 16 months male

In three of the four cases the carer became aware of the drowning incident during a routine check of the child.

When I returned to the bathroom, I saw DECEASED floating face up in the bath. [Mother's statement - Case 4460/1989] 2.5 years male

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I then got a roll of frozen pastry out of the freezer and went in to check DECEASED and he was lying face down in the bath. [Mother’s statement – 2057/1991] 2.5 years male

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I then got up and returned to the bathroom where I found DECEASED lying on his side. [Mother’s statement – 1348/1994] 16 months male

In the remaining case the carer was alerted to the incident when they realised that they could no longer hear the child playing in the water.

Some time later, approximately 5 minutes, the mother realised that there was no sound coming from the bathroom and went to investigate. Mother found the child face down in the water.
Supervision Level 2

In four of the 22 (18%) deaths, two males and two females, the child was bathing alone and carer supervision was categorised as level 2. The average age of the child was 14 months and the average age of the carer was 25 years (18 – 34).

In all four cases the carer was the mother of the deceased and in three of the four cases their occupation was recorded as “home duties”. Carers reported being absent from the bathroom for between one and five minutes and in three of the four cases the Coroner made a finding of contribution against the carer. The carer left the child unsupervised, in two cases placed in a bath seat, in order to prepare the child’s clothes.

I put DECEASED in the bath, I went to get her clothes and heard a splash, when I went back in the bathroom DECEASED was lying under the water. [Mother’s statement - 0445/1990] 20 months female

While DECEASED was in the bath, I was in there with him and we were playing with his toys. He was laughing and when I finished washing him, I left him in the bath for one minute, or it could have been five. I went to the lounge room to get DECEASED’S clothes ready as I always dressed him on the sofa in there. [Mother's statement - Case 2434/1995] 16 months male

At this time I realised that I hadn't got her clothes ready so I went into her room and got a nappy, liner and plastic pants. I took these items to the lounge room and folded the nappy in the lounge room and left it and the plastic pants on the floor. I then went into our bedroom and got a singlet off the clothes horse and took it into the lounge room and dropped it on the floor next to the nappy. At this time I heard splashing sounds coming from the bathroom. I stopped and listened from the hall and heard DECEASED’S voice and I assumed she was okay and just playing. She would always splash and play in the bath and seemed to enjoy her baths. I thought she was all right and thought that I would just quickly go into her room and get her clothes. [Mother's statement - Case 2385/1996] 13 months female

I put him in the bath in his little round seat that he had, with the little toys on the front where they were glued onto that little seat. I undone (sic) the clips, I put bubby in it and I clipped him back in and I put water in the bath, up to his chest. I just said to bubby, "I'm just gonna get your clothes and I'll be back". He was playing and splashing around and I heard the splashing and that and when I didn't hear a splash, I walked back in the bathroom and I think it was only a minute, or maybe a little bit longer, I'm not sure on the time, when I went and checked him, I seen (sic) him out of the seat. He must've crawled out of it or something and when I saw him, he was floating on the top. [Mother's statement - Case 2678/1999] 8 months male
Carers became aware of the drowning incidents for various reasons, such as: a routine check; asked by another person where the child was; heard a splash in the water; and realised that they could not hear the child in the water.

**Not Bathing**

In three of the 25 (12%) cases the young child drowned in a bathtub in circumstances other than having a bath. The carers assumed that the deceased was happily playing around the house and became aware of the drowning incident when they realised that the child had not been seen or heard for some time. In two of these cases the child fell in a bathtub full of water from a sibling's bath.

_I thought DECEASED was in the front play room but she wasn't. ... I then realised that I hadn't checked the bathroom, the door was closed as usual and it didn't occur to me to look there. I then opened the door to the bathroom and saw DECEASED floating face down in the bath in the water that I had previously washed BROTHER in. ... Usually I'm careful with the bath water and empty it out, as well as keeping the door to the bathroom closed._ [Mother's statement - Case 1968/1993]

**18 months female**

The bath water, it would appear was left in the bath after MOTHER bathed another child mid-morning. Apparently DECEASED was quite capable of climbing and could have climbed into the bath or at least onto the edge and tumbling into the water. There are pipes exposed against the bath, these may have been used by DECEASED as a foothold to assist her climbing the bath. DECEASED had a fascination with water, this combined with toys in the bath may have enticed DECEASED to climb the bath edge. It would appear that DECEASED may have been in the bath for a least an hour. [Investigating Police Member's Statement - Case 1968/1993]

**18 months female**

We were all watching T.V. and playing on the computer in the lounge room. After a short time all three kids left the lounge and went into the girls room, they were playing barbies. After about fifteen minutes SISTER (7 years) came into the lounge, where FATHER and I were, and asked if they could watch a video in the toy room, which is to the rear of the house. I said that was fine, at this point I assumed DECEASED was still with the girls, as he always follows them around. DECEASED was able to crawl and could walk if he supported himself on something or someone. I said to SISTER (7 years), "Where's your brother", she told me that she didn't know, I told her to look for him. After about five minutes SISTER didn't answer me about where DECEASED was, so I called out to her again to look for him. I could hear her running from the toy room toward her bedroom, after about half a minute I heard SISTER (7 years) screaming. She yelled out "He's in the bath". ... When I found DECEASED in the bath the water was maybe a foot deep, the water had been in there from the girl's bath the night before. [Mother's statement - Case 2520/1999] **13 months male**
Looking back, I suppose DECEASED could have been in the bath for twenty minutes, at the time I was organising business cards on the computer and just assumed he was with his sisters as he usually was. [Father's statement - Case 2520/1999] 13 months male

In the third case the deceased fell in the bathtub whilst it was running. The carer was unaware that the child was in the bathroom, assuming that he was watching television, and had left the bath running while she prepared the child’s clothes.

MOTHER turned on the water to have a bath with DECEASED. She left the water running and went into another room to prepare some clothes and a towel for him when he had finished his bath. At this stage she was under the impression that DECEASED was still watching television. She returned to the bathroom after about four minutes to find DECEASED laying face down in the bath with his clothes on. [Coroner's finding - Case 1344/2001] 2.5 years male

In all three cases the Coroner made no finding of contribution against the carer. These incidents were similar in nature to drowning incidents of young children in other bodies of water around the home - carers assuming that children are content entertaining themselves around the house, oblivious to the danger of contained water accessible to the child.

**Bath Seats & Rings**

Amongst the 25 cases, there were three where the deceased was placed in a bathtub seat or ring and left unattended while their carer tended to the washing, other people in the house and the child’s clothes.

The flotation device is designed to put a baby’s legs through with a section at the back, which supports the child’s head when it lays back. There is a central restraining strap that is designed to stop the baby falling through the device. The evidence satisfies me that the device was correctly inflated and fitted to the deceased, it having been used often in the past with no problems having been experienced. The device carries a manufacturer’s warning stating that it should not be used unsupervised. … The evidence does not enable a determination as to the appropriateness of the flotation device being readily available, as its identity cannot be ascertained. I am satisfied, however that it carried a warning that the device should not be used unsupervised. [Coroner’s Finding – 4101/1992] 8 months male

I went into the bathroom to watch the boys. BROTHER (2 years) sat in the bath unassisted and I put DECEASED in a blow up “floatee” device. This “floatee” is designed to put the baby’s legs through, with a section at the back, which supports the baby’s head when they lay back. The strap in the middle of the “floatee” stopped the baby falling through. When I put DECEASED into this “floatee” I placed him in it correctly. DECEASED was often bathed using the “floatee” and we had never experienced any problems with it. I made sure both boys were right in the bath, they seemed content, so I left the bathroom and walked into the lounge to speak to some relative. During the course of this conversation, I went back and forth into the bathroom on several occasions to check the boys. On the last occasion that I checked, I
walked into the bathroom and observed DECEASED floating face down in the water and the “floatee” also floating. [Father’s statement – 4101/1992] 8 months male

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From the evidence presented, I find that DECEASED has just started to stand on her own but was unsteady on her feet and may have over balanced in the 'Stay and Play' in the bath. The 'Stay and Play' is marked with the warning 'To prevent drowning, never leave a child unattended'. Therefore MOTHER OF DECEASED by leaving her daughter in the bath unattended with the knowledge that her daughter has started to stand up without assistance, contributed to her daughter's death. [Coroner's Finding - 2385/1996] (See Appendix 1).

13 months female

This seat consisted of solid plastic ring with moulded back support supported by four solid plastic legs affixed to a rubber base. The underside of the base consisted of concentric circles of small suction cups used to fix the seat to the bottom of the bath. On the rear of the moulded back support of the seat was a printed warning label in red lettering which read: WARNING = To prevent drowning never leave child unattended. [Investigating Police Officer's Statement - 2385/1996] 13 months female

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By way of comment, it cannot be stressed often enough that babies and toddlers should not be left unsupervised in potentially dangerous situations for example, bathtubs, and the use of devices such as the "safety" seat does not obviate the responsibility of carers. [Coroner's finding - 2678/1999] 8 months male

In all cases the child was placed in the bathtub seat / ring correctly and the device was reported to be in good condition. However, these devices are designed to be used as a bathing aid only and in addition to constant supervision. In two of the cases, a warning containing this advice was printed on the device. Despite this, in each case, the child was left unsupervised unnecessarily for a period of time. The child either slipped or crawled out of the device and subsequently drowned. Since the completion of data collection for the current study, three children under five years of age have drowned in bathtubs in Victoria, one in 2002, one in 2003 and one in 2004. One of these cases involved the use of a bathtub seat.