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 Coronal 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 were:

1. Keyword search conducted on the TOPIC database, which contains electronically stored police report summaries and Coroner's findings. Electronic versions of police report summaries (known as “Form 83 circumstances text”) and Coroner's findings were searched using keywords such as pool; swimming pool; spa; 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. 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).

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 private swimming pool or spa and the deceased was aged between 0 and 5 years.


An SQL search was conducted of 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. Search of the Victorian Coronal Facilitation System (VCFS) provided by MUARC, verified using the publications titled Unnatural Deaths: Collated from the findings of the State Coroner.

The Monash University Accident Research Centre (MUARC) provided the SCO with a copy of the Victorian Coronal Facilitation System (VCFS). The VCFS is a database containing information on all closed cases (cases where the Coroner had made a

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4 Cases were identified from 1989 to 2001 in order to illustrate the extent of these deaths. Only cases from 1997-2001 were included in the current study as other Victorian research had been previously undertaken, see Blum and Shields (2000).

5 TOPIC is maintained by VIFM for use by Coronial Services Centre staff.
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 & 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. Search of the National Coroners Information System (NCIS) for all deaths where the Mechanism of Injury = threats to breathing, drowning and immersion and the Object or Substance Producing Injury = building, building component or fitting, swimming pool (above ground and in ground) or external spa bath for deaths that occurred from July 2000 to December 2001.

The NCIS is a national database that stores information on all deaths reported to the Coroner in Australia from July 2000. For the purposes of case verification, a search of the NCIS was conducted using the query design function. The criterion specified in the search is outlined in Table 7.

**TABLE 7**

<table>
<thead>
<tr>
<th>Data Item</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>State / Territory</td>
<td>Victoria</td>
</tr>
<tr>
<td>Age</td>
<td>0 - 5 years</td>
</tr>
<tr>
<td>Mechanism of Injury</td>
<td>J. Threats to Breathing</td>
</tr>
<tr>
<td></td>
<td>J2. Drowning and Immersion</td>
</tr>
<tr>
<td>Object / Substance Producing Injury</td>
<td>R. Building, Building Component or Fitting</td>
</tr>
<tr>
<td></td>
<td>R13. Swimming pool - above ground</td>
</tr>
<tr>
<td></td>
<td>R14. Swimming pool - in ground</td>
</tr>
<tr>
<td></td>
<td>R15. External Spa Bath</td>
</tr>
</tbody>
</table>

**Data Collection**

In 20 cases the Coroner had completed the investigation and made a finding regarding the death. The information collected by the police during the death investigation was therefore available. 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.

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6 All States and Territories have been contributing data to the NCIS since July 2000, with the exception of Queensland, who have been contributing data since 1 January 2001.
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 below in Table 8.

### TABLE 8
**List of data items**

<table>
<thead>
<tr>
<th>Name</th>
<th>Case Status (open/completed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deceased's Age (years and months)</td>
<td>Deceased's Gender</td>
</tr>
<tr>
<td>Carer/s Age</td>
<td>Carer/s Gender</td>
</tr>
<tr>
<td>Carer / Deceased Relationship</td>
<td>Carer/s Mental or Physical Illness</td>
</tr>
<tr>
<td>Deceased's Mental or Physical Illness</td>
<td>Date, Day and Time of Incident</td>
</tr>
<tr>
<td>Season</td>
<td>Suburb</td>
</tr>
<tr>
<td>Postcode</td>
<td>Location (rural or urban)</td>
</tr>
<tr>
<td>Type of Pool (above or in ground pool)</td>
<td>If Visitor, Deceased's Relationship to Dwelling Owner</td>
</tr>
<tr>
<td>Type of Spa ([attached or independent of a pool) (above or in ground)]</td>
<td>Deceased's Activity According to the Carer/s at the Time of the Incident</td>
</tr>
<tr>
<td>Carer/s Activity at the Time of the Incident</td>
<td>Time Period Estimated by Carer/s since Deceased Last Seen Alive</td>
</tr>
<tr>
<td>Carer/s Location in Relation to the Deceased</td>
<td>Was the Deceased Participating in Water Recreation at the Time of the Incident?</td>
</tr>
<tr>
<td>Deceased Resident or Visitor to the Dwelling where the Incident Took Place</td>
<td>Adequate Supervision within the Time Period Prior to the Incident</td>
</tr>
<tr>
<td>Was the Deceased Wearing a Safety Device?</td>
<td>Carer/s Alert to Drowning</td>
</tr>
<tr>
<td>Presence of a Distraction to Supervision</td>
<td>Year of Pool Construction</td>
</tr>
<tr>
<td>How did Deceased Access Pool Area</td>
<td>Child’s Behaviour Around Water</td>
</tr>
<tr>
<td>Did the Safety Barrier Comply with Legislation</td>
<td>Did Safety Barrier Non-Compliance Allow the Deceased Access to the Pool</td>
</tr>
<tr>
<td>Carer/s Awareness of Safety Barrier Requirements</td>
<td>Number of Adults and Children Present at the Time of the Incident</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:

- deaths per year (1989 – 2001);
- age and gender;
- time of day;
- day of week;
- time of year (season and month);
- location (residence and region); and
- type of pool/spa.

#### Qualitative

Groups of cases were examined according to factors identified as associated with or contributing to the drowning incident. The factors identified consisted of:

- presence and efficacy of safety barriers; and
- carer supervision.
Pool Type & Presence & Efficacy of Safety Barriers

Each case was allocated to one of five groups according to the type of safety barrier that surrounded the pool/spa. Each case was assessed according to the type of barrier present (see Table 9) and whether the safety barrier was compliant with the relevant regulations using the definitions proposed by Barker et al. (2003). Barker et al. (2003) propose the following safety barrier definitions.

TABLE 9
Pool fence location definitions from Barker et al. (2003)

| Perimeter fencing | the boundary of the house allotment has a fence restricting access to the property by a toddler but there is no restriction of physical access for toddlers from the house to the pool. |
| House containment | the only fence restricting access to the pool is perimeter fencing but all doors and windows in the house restrict access to the pool by a toddler. |
| 3-sided fencing | a fence and building wall restricts access to the pool by a toddler but there is restricted access via a house-door from the house to the pool. |
| 4-sided fencing | a fence or building wall restricts access to the pool by a toddler and there is no direct door access from the house to the pool but may include a window. |
| Isolation fencing | as for four-sided fencing except all ancillary structures (not related to the function of the swimming pool) excluded from the pool area and a maximum distance between the pool fence and the edge of the pool is prescribed. |

Barker et al. (2003) also proposed two levels of safety barrier compliance for fenced pools: static compliance and dynamic compliance. Static compliance was defined as:

the ability of the fence or access point to meet relevant Australian Standards for restricting access to the pool by a toddler after all temporary impediments to compliance are removed (page 3).

Dynamic compliance was defined as:

the absence of temporary impediments of a non-structural nature that impair the barrier function at the time of a drowning or near-drowning incident (e.g. a rope tying a pool gate open) (page 3).

Cases were assessed in this manner in order to determine whether the non-compliance was related to the barrier's structure or a result of human interference with the structure. Cases were also assessed in terms of the whether the barrier's point of non-compliance was also the point at which the child gained access to the pool / spa in order to establish the degree of contribution to the death.

Carer Supervision

For the purposes of data analysis, cases were allocated to one of two groups according to whether the child was last seen by their carer inside the house or whether the child was located outside the house and in the vicinity of the pool or spa. Each case in both groups were assessed in relation to:

- carer activity;
- location of carer;
- estimated time left unsupervised;
- child activity according to the carer; and
- alert to carer of missing child.
Limitations of the Data Source

Data Source
The data source utilised in the current study consisted of information submitted to the State Coroner's Office 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.

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 can 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 of circumstances and Coroner's finding) for cases completed in rural Victoria prior to 2000 are not all stored on the SCO LCMS. As a result a key word search using TOPIC would miss these cases.

The accuracy of textual information is also problematic, particularly in terms of 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 completed 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

There were 20 children aged between 0 and 5 years who drowned in private swimming pools and spas between 1989 and 2001.

Trend Over Time

The frequency and distribution of drowning deaths of 0-5 year old children in private swimming pools and spas between 1989 and 2003 in Victoria is illustrated in Figure 2. There was a decrease in the number of deaths per annum during this period.

FIGURE 2
Drowning deaths of 0-5 year old children in private swimming pools & spas, 1989-2003 (n=82)

Age and Gender

Thirteen (65%) deceased were male, ten of whom were aged between twelve months and forty-eight months.

FIGURE 3
Frequency of drowning incidents by age and gender, 1997-2001 (n=20)

7 Figure 2 illustrates the number of deaths between a larger period of time than the study period.
**Time of Day**

Ten (50%) of the incidents occurred in the evening between 6:00 pm and 8:59 pm. A further seven cases (35%) occurred in the afternoon, between midday and 5:59 pm.

![Time of Day Graph](image)

**FIGURE 4**
Frequency of drowning incidents by time of day, 1997-2001 (n=20)

**Day of Week**

Half (50%) of the deaths occurred on the weekend.

![Day of Week Graph](image)

**FIGURE 5**
Frequency of drowning incidents by day of the week, 1997-2001 (n=20)
**Time of Year**

Sixty percent of the incidents (n=12) occurred during the summer months, December to February.

**FIGURE 6**  
Percentage of drowning incidents by season, 1997-2001 (n=20)

December had the highest frequency of drowning deaths (n=5, 25%) during the five year study period (Figure 7).

**FIGURE 7**  
Frequency of drowning incidents by month of year, 1997-2001 (n=20)
Location of Incident

Residence
There was a relatively even distribution between the frequency of incidents that occurred at the deceased's own premises (55%), and incidents that occurred at a premises the child was visiting (45%) (Figure 8).

![Pie chart showing distribution of incidents by location.](image)

FIGURE 8
Percentage of drowning incidents by location, 1997-2001 (n=20)

Region
Seventy-five percent of the incidents (n=15) occurred in a swimming pool or spa at an urban location (Figure 9).

![Pie chart showing distribution of incidents by region.](image)

FIGURE 9
Percentage of drowning incidents by region, 1997-2001 (n=20)
**Type of Pool / Spa**

Twelve (60%) of the twenty incidents occurred in an in-ground swimming pool, six (30%) occurred in an above ground swimming pool and two (10%) occurred in a spa. One of the spas was above-ground and one was in-ground.

![Figure 10: Frequency of drowning incidents by type of pool, 1997-2001 (n=20)](image)

**Other Factors**

The overall findings of the study were that safety barriers were not compliant with the relevant requirements (including barriers not operating correctly at the time of the incident) and carer supervision was absent immediately prior to the incident. This breakdown in barrier effectiveness and supervision enables the young child to drown.

In all 20 coronial investigations, it was concluded that at least one of these factors contributed to the death of the child. In 14 of the 20 incidents (70%) it was concluded that the death resulted from a combination of both factors. For the purposes of data analysis these factors were examined separately.

**Safety Barriers**

There were a variety of safety barrier types surrounding the pools and spas in the current study. Cases were grouped according to Barker et al's (2003) safety barrier definitions (See Table 8):

- perimeter fencing;
- house containment;
- 3-sided;
- 4-sided; and
- isolation
In one case the barrier was an isolation fence, in two cases the safety barrier was 3-sided, in three cases there was no safety barrier, in seven cases there was a 4-sided barrier and in another seven cases the safety barrier consisted of house containment (Figure 11).

**FIGURE 11**
Percentage of drowning incidents by safety barrier type, 1997-2001 (n=20)

Isolation Safety Barrier (n=1)

In one case the in-ground pool was surrounded by an isolation safety barrier (See Appendix 1, Photograph 12). In this case the child was left unattended inside the house and entered the rear yard via a sliding door. The child accessed the pool by pulling open the gate, which was not operational at the time of the incident due to lack of maintenance.

*The gate was out of plumb by approximately 5 millimetres. When testing the operation of this gate it was also noted that the gate slightly touched the buckles on the post when closing, and on certain occasions not engaging the latch to self-lock. It appears that the tree root had contributed to a slight uplift of the subject gatepost, which could have been part of the reason why the gate was out of plumb. Due to lack of maintenance and the uplifting paving, the gate was out of plumb which caused the gate to not engage the latch and self-close on all occasion. [Building Surveyor's report - 3730/1999 - 22 months female]*

Three-Sided Safety Barrier (n=2)

In two cases the pool / spa was surrounded by a three-sided safety barrier (See Appendix 1, Photograph 1 and 16). In one case the pool was in-ground, and it was not specified in the coronial file when the pool was constructed. At the time of the incident the child was engaged in water recreation with adult supervision and prior use of flotation. Subsequently the safety barrier was not the focus of the investigation.

The other case involved an in-ground spa constructed after April 1991, therefore the safety barrier was required to comply with AS 1926.1. The child was left unattended inside the house, accessed the spa area via a sliding door that was later found to be non-compliant. The reason for non-compliance was that the sliding door was not self-closing or self-latching, and the latch was located less than the prescribed 1.5 metres from the ground (See Appendix 2, Photograph 7).
No Safety Barrier (n=3)

In three (15%) cases there was no form of safety barrier. In all three cases the pool was located on a property in rural Victoria. Two of the three pools were in-ground pools and one was an above-ground pool. Both the in-ground pools were in the process of being constructed and the deceased had engaged in water-recreation in the pool earlier in the day. Contrary to AS 1926.1, the relevant safety barrier requirements, the pool had been filled with water prior to the erection of a safety barrier (See Appendix 1, Photographs 6).

... my wife and I started to fill the pool with water and fill around the outside of the pool with stabilising sand. I placed four sheets of reinforced steel mesh over the pool when I had finished to prevent anything or anyone falling into the pool. The pool fence could not be erected at this stage as machinery was needed to place sand around the outside of the pool, that is why I used the mesh to cover the pool. ... I went to my business factory to build the fence for the pool. I completed the fence and had some of my workers deliver the fence to a powder coater. I needed the fence to be coated as we were planning on having a few friends over for a party. The day before the party I picked up the fence and all the other bits and pieces needed to erect it. It took me longer to finish back filling around the outside of the pool than I anticipated so I was not able to erect any of the fence. The mesh was placed over the pool all the time I wasn't working on it. [Father's statement - 3805/1998 (3 years female)]

In all three incidents the child was known by their carers to be playing in the yard of the property immediately prior to the incident. The absence of a safety barrier allowed these children unrestricted access to the pool.

Four-Sided Safety Barrier (n=7)

In seven (35%) cases the pool / spa was surrounded by a four-sided safety barrier (See Appendix 1, Photograph 2, 4, 5, 13 and 14). Three of the pools were above-ground and four pools were in-ground. There were only three cases where the year of pool construction was specified in the coronial file (See Appendix 1, Photographs 2, 5, 13, and 14). In two of these cases the safety barrier was required to comply with AS 1926.1. In one of these two cases the fence did not comply because the fence, constructed from trellis, contained footholds and the gate was neither self-latching or self-closing. In the other case the safety barrier complied with AS 1926.1, however the gate was propped open by a rock.

When I put the fence and gate up, I believed that I had made the pool as safe as it could possibly be. The lock on the gate was well out of reach of children and I felt that the fence was well constructed to keep children out. We also have locks to the two gates which lead into the back garden and the back door has a security fly screen door which has a dead lock to it. Since DECEASED'S death a council officer has visited my home and told me that the gate to the pool should have been self-closing. I did not know this. I sincerely believed that I had made the pool safe. [Grandfather's statement - 0185/1998 - 3 years male]
Whilst inspecting the area I located a medium sized garden rock near the eastern most pool gate. This rock did not restrict the gate from opening or closing when I tested the gates, but it was very close to the gate when it was entirely open. There were several marks on the rock. These marks appeared to be the same colour as the pool fence and gates. After observing the location of the rock and the marks on it I formed the belief that the rock may have been used to prop open the gate. [Investigating Police Officer's statement - 0147/2000 - 2 years male]

I now know that the main gate was propped open by a rock, totally open so that there was a gap there. I know now it was a family practice, but I had no idea that the gate was being propped open on the day. [Mother's statement - 0147/2000 - 2 years male]

In one of the three cases where year of pool construction was specified in the coronial file, the safety barrier was required to comply with Reg. 5.13. In this case the safety barrier was compliant with Reg. 5.13 however the double gates leading directing into the pool area were kept open throughout the day to allow access to the pool. The gate was kept open with the bolt in the ground on one side and by a rock on the other side.

Although the fence was fitted with gates, on this particular day they were left open to make access to the pool more convenient. ... I believe that under the circumstances the access gate to the pool area should have been closed on the day of DECEASED'S death. If this had been the situation it is possible that the incident would not have occurred. [Coroner's finding - 0404/1997 - 3 years male]

In the remaining four cases where year of pool construction was not specified, the safety barrier would not have complied with either Reg. 5.13 or AS 1926.1 for such reasons as: the barrier gate was not self-latching; the height of the barrier was not at least 1.2 metres; or an entire section of the barrier was missing (See Appendix 1, Photograph 4).

In terms of pool access, there was one case where it could not be determined how the deceased entered the pool area. In three cases the deceased was known to be playing in the rear yard where the pool was in the vicinity, one having previously engaged in water recreation. In the remaining three cases, the deceased exited the house via a sliding door and entered the pool area via a gate that was either left open (n=2) or not in proper working order (n=1).

House Containment Safety Barrier (n=7)

In seven (35%) cases the style of safety barrier was house containment. Three of the pools were above-ground (two pools, one spa) and four pools were in-ground. In four of the five cases where information was available, the pool was constructed prior to April 1991 and was subject to Regulation 5.13. In all four cases the sliding door leading from the house to the pool area was non-compliant with Reg. 5.13, because it was not self-latching and the latch was not located 1.5 metres above the internal ground level8.

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8 It should be noted that self-latching doors and gates are a requirement of AS 1926.1, therefore if these barriers were tested against this generally more stringent requirement, they would also be non-compliant.
I must have let DOG out either during or just after breakfast. I let her out into the pool area via the sliding door from the family room. It was unusual that I let her out there as I usually let her out the back or the front. ... I can't remember whether I locked the door after letting DOG out or not, but I mustn't have, because DECEASED couldn't reach that bolt. I went up to get dressed and make the beds. I came back to make a coffee and then I thought, "I can't hear him". [Grandmother's statement - 3034/1999 - 2 years male]

The exit points from the house did not meet the requirements. The requirement is that both the door [sliding door] and any accompanying screen door exits be fitted with a self-locking or self-latching device and least 1.5 metres about the internal floor level. The glass doors did not meet this requirement. The lounge and dining room wire screen door did meet the requirement of the self-locking and self-latching device but the dining room wire screen door also did not fully close. It stopped approximately one to two centimetres away from closing which enabled people to be able to enter and exit the house without having to use the lock. [Investigation Police statement - 3167/1999 - 3 years male]

The doors [sliding doors] were not fitted with self-latching devices located 1.5m above the floor. The gates leading from the front of the property did not meet the requirements for a gate forming part of a pool safety barrier i.e. they were not self-latching with the latch located 1.5m high. [Investigating Police statement - 3447/1999 - 2 years female]

The house was not considered a suitable barrier because the sliding door was not self-latching and the latch was not located 1.5 metres above the floor level; the windows were also non-compliant as was the laundry door. [Building Surveyor's statement - 0469/2000 - 8 months female]

In two of these four cases (3034/1999 and 0469/2000), this door was the point at which the deceased exited the house and accessed the pool area (See Appendix 2, Photographs 3-5). In the remaining two cases the child was known by their carers to be playing outside the house in the vicinity of the pool.

I do not consider that failure to comply with the regulations had any bearing on the outcome in the case. The child was not alone beside the pool and was in the presence of an adult. Due to misunderstanding, FAMILY FRIEND believed that the child had gone back inside the house. Of course, even if she believed this, there was always the chance that the child would come out again as the door was unsnibbed. Clearly this was a case of human error. [Coroner's finding - 3167/1999 - 3 years male]

It is not at all clear that the non-compliance with the building requirements had any role in the outcome. It would seem that the child managed to climb up to the upper surface of the pool by climbing up the filter and pumps assembly. Her mother was aware that she was in the boundaries of the pool.
enclosure. She appears to have been concealed by the walls of the above ground pool until it was too late. [Coroner's finding - 3447/1999 - 2 years female]

In the remaining case where information was available, the pool was constructed after April 1991 and was subject to AS 1926.1 (See Appendix 1, Photograph 3). The pool was constructed without the required permit from local council and there was no information in the file pertaining to the adequacy of barriers from the house to the pool. In this case the issue was irrelevant, as the child was known by both carers to be playing in the yard in the vicinity of the above-ground pool. It was noted by the coroner that a safety barrier erected between the pool and the rest of the yard may have prevented the drowning, a finding pre-empted by the parents of the child in their statements.

From the evidence presented I find that DECEASED'S death was a tragic accident. I further find that if a fence has been erected the incident may not have occurred and that parental supervision should have been more effectual with young children in the near vicinity of a swimming pool. I further find that MOTHER and FATHER contributed to the death of the deceased by failing to keep a proper lookout. [Coroner's finding - 0496/1997 - 19 months female]

When I put the pool up I did not put a fence around it. I do blame myself a bit for DECEASED'S death because I should of put a fence up and I should of kept watching her when she was around the pool. [Father's statement - 0496/1997]

When FATHER and the others put the pool up a fence was not put up. FATHER mentioned to me about a fence for the pool from his mother but unfortunately his brother was using it to keep a dog in. I do feel a bit responsible for DECEASED'S death because we did not put up a pool fence when we built the pool. [Mother's statement - 0496/1997]

In the remaining two of the seven cases with house containment safety barriers, it was not specified in the coronial file when the pool was constructed. Despite this, in both cases the safety barrier, a sliding door, was non-compliant with both Reg. 5.13 and AS 1926.1 because the door was not self-latching in one case and in the other case the latch was not located at least 1.5 metres from the ground (See Appendix 2, Photographs 1 and 2).

Barrier Compliance

For the purposes of data analysis and comparison with other Australian data, the safety barrier in each case was assessed according to Barker et al’s. (2003) two levels of barrier compliance: static and dynamic (See Method for definition).

As stated in the above definitions the relevant standard for static and dynamic compliance assessment is AS 1926.1. The incidents examined in the current study occurred prior to the 2001 amendments to Reg. 5.13 bringing it in line with AS 1926.1, therefore there were a number of pools that were not required to meet AS
For the purposes of completeness the static and dynamic compliance assessment was made in relation to the relevant regulation as well as to AS 1926.1. (See Appendix 5 for summary).

**Pre-1991 Pools - Regulation 5.13 (n=6)**

In all six cases the safety barrier failed static compliance, five of which also did not comply with Reg. 5.13. In all cases the point of non-compliance was the absence of self-latching devices on gates and doors. In four of the six cases this point of non-compliance was also the point at which the deceased accessed the pool. In the remaining two cases the deceased was in the vicinity of the pool, both of which were house containment barriers.

**Post-1991 Pools - AS 1926.1 (n=6)**

Four of the six safety barriers failed static compliance due to an absence of a barrier (n=2) or an absence of a self-latching and self-closing device on the door or gate leading to the pool (n=2). One barrier maintained static compliance, but failed dynamic compliance because the pool gate was propped open by a rock. In the remaining case there was not enough information to determine compliance.

In three of the five cases where the safety barrier failed static or dynamic compliance, it was also the point at which the child accessed the pool area. In the two remaining cases barrier non-compliance was irrelevant as the deceased was located in the vicinity of the pool. The types of safety barriers in these two cases were house containment and no barrier.

**Year of Pool Construction Not Specified (n=8)**

Seven of the eight barriers where the year of pool construction was not specified in the coronial file failed static compliance due to an in-operable self-latching device on the door or gate leading to the pool, absence of a self-latching or self-closing device, missing section of fence or inadequate fence height. In the remaining case, the safety barrier was not applicable to the drowning incident as the deceased was engaged in water recreation in a pool surrounded by a three-sided safety barrier.

Four of the seven cases where the safety barrier failed static compliance were also the point at which the deceased accessed the pool. In two of the seven cases the deceased was in the vicinity of the pool, four-sided and no barrier, and the non-compliance was not a factor in the drowning. However, if there was a barrier between the pool and the yard the drowning may not have occurred. In the remaining case the coronial investigation was not able to determine how the deceased accessed the pool.

Irrespective of the year of pool construction (and therefore the two types of regulations) it was found that 16 of the 20 safety barriers (80%) failed static compliance. In almost 70% of these cases (n=11) the reason the barrier failed static compliance was because the door or gate leading to the pool was either not self-latching or the self-latching device was in-operable at the time of the drowning incident. This is an important finding given that both Reg. 5.13 and AS 1926.1 required doors and gates to be self-latching and has done since 1991 in Victoria. It is also important to note that eight of the eleven cases where the barrier failed static compliance as a result of an absence of or in-operative self-latching device, was also the point at which the deceased accessed the pool. That scenario represents 40% of all incidents.
In the large majority of cases it was not possible to determine why the pool owner had not complied with the relevant regulations. However, the following statements reveal that in some cases there was an awareness of pool safety barrier regulations and owners thought that their safety barrier complied.

_When I put the fence and gate up, I believed that I had made the pool as safe as it could possibly be. The lock on the gate was well out of reach of children and I felt that the fence was well constructed to keep children out. We also have locks to the two gates which lead into the back garden and the back door has a security fly screen door which has a dead lock to it. Since DECEASED'S death a council officer has visited my home and told me that the gate to the pool should have been self-closing. I did not know this. I sincerely believed that I had made the pool safe._ [Grandfather's statement - 0185/1998 - 3 years male]

_I always kept the door locked that led to the pool. The door is a sliding door, there is two of them. I have got those locking bolts for the top for both of them. They are always kept locked so that he can't go out without me being aware of it. The pool is also surrounded by a fence. I had all those things done before he got mobile._ [Grandmother's statement - 3034/1999 - 2 years male]

_The pool was built before the current pool fence regulations, we are not required to have a safety fence around it. All we were required to do was have the locks on the doors raised (above children's reach) and a similar extra lock on the gate (as well as a spring system to have the gate close automatically). Although it wasn't required dad actually had a fencing contractor come in and put up a brand new higher fence around the two sides and the rear of the house. It was just an added precaution for the pool. We never had any trouble with the pool, we thought we had everything covered._ [Family friend's statement - 3167/1999 - 3 years male]

_I obtained a quote to install a pool fence and set about obtaining two more quotations. I accepted the first quote and posted the deposit. At the date of the incident the pool fence had not been erected._ [Father's statement - 3693/1999 - 11 months female]

_To close the gate, you pull it shut towards you if you are on the outside. I would say you would have to pull the gate abruptly to close it to make sure the latch has connected onto the pole of the gate. We have told the children to be aware of this and to make sure that it is done so that it is not left open as it has been left open in the past. The Friday before DECEASED drowned my brother-in-law rang the council from our house and arranged an Amnesty on the pool fence as it was not compliant. As far as I am aware we were granted this amnesty. ... we had asked the council to come around and inspect our pool fence. They came around but just handed by brother-in-law the guidelines for a pool fence. We had an idea that our fence was not..._
compliant and when we became aware of their guidelines, we decided to make it compliant. Our fence had to be 1.2 metres high and the steel squares had to be 1 inch by 1 inch. Also the fence was required to go all the way around the pool and ours didn't. Finally we had to have a gate that opened out and away from the pool and automatically closed behind you. [Father's statement - 0469/2000 - 8 months female]

These statements indicate that pool owners were aware that regulations regarding pool and safety barrier construction existed. However pool owners did not know the exact nature of these requirements. A number of pool owners erected a pool without a permit, and later claimed that they were not aware that they were required to obtain one. Other pool owners constructed a pool and filled it with water prior to the erection of a safety barrier, only to have their child drown within days. Some erected barriers without first obtaining any information from the council and after the drowning incident were advised by the council's surveyor that "the barrier contained footholds and pad locks were not an appropriate latching device". It appears that the will to comply with regulations and / or protect their young children from drowning existed in these cases. However, pool owners did not obtain the necessary information from the council to construct safety barriers correctly. This illustrated that local councils need to be more proactive in terms of raising awareness within the local community about the need to obtain a permit to install a pool or spa and safety barrier requirements. This should be followed up by regular pool inspections.

**Carer Supervision**

In all 20 cases carer supervision was found to be absent immediately prior to the drowning 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.**

For the purposes of determining the adequacy of carer supervision it was necessary to examine the incidents in terms of where the young child was thought to be located by their carer immediately prior to the incident. That is, inside the house or outside the house. This factor has some bearing on the assessment of "adequate supervision".

When each case was examined by child location, it was found that there were two distinct chains of events that led to the drowning incident. One group (n=10) where the young child was left unattended inside the house from which they then exited, unbeknown to their carer, entered the swimming pool or spa and subsequently drowned. In the second group of incidents (n=10) the child was known by their carer to be located outside the house and in the vicinity of the pool or spa. It was anticipated that greater vigilance in terms of supervision should have been demonstrated by carers when the young child was known to be outside in the vicinity of a pool / spa.

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9 Source: RLSSA, Victoria Branch. *Keep Watch* brochure.
Carer Supervision when Child Located Inside House

In ten cases the carer believed that the child was inside the house immediately prior to the drowning incident. In all cases the carer was located in another room of the house from the young child. Carers reported either attending to themselves or another child (n=4), engaging in home duties (n=3) or other unspecified activities (n=3). In most instances, the carer reported leaving the child unattended for a period of at least ten minutes, assuming that they were "playing around the house".

In six of the ten cases, the young child exited the house via a door (n=4, sliding door) negotiated another barrier and entered the pool. In the remaining four cases, the young child exited the house via a sliding door, which led immediately to the pool areas. All four doors that lead directly to the pool/spa area were found to be non-compliant with the relevant regulation, namely that the doors were not self-latching and the latch was not located 1.5 meters above ground level. In the cases where a barrier was present around the pool/spa, the gate was either in operable or propped / left open.

Excerpts from the witness statements regarding supervision immediately prior to the incident are illustrated below for all ten incidents.

Incident 1

I have to supervise them because they are very active, and otherwise they turn everything upside down. ... my husband the four children, and myself were in my husband's room at the back of the house. The back door, which is used as the main entranceway to the house and has a flick type lock, was locked. I went to the toilet for a short time, I would guess about 10 minutes. I have looked after the children for about a year, and during that time they sometimes have been able to unlock the back door and go inside, but because I look after them and they rarely leave my sight, they cannot go far in the period of time it takes me to go to the toilet. [Grandmother's statement - 2673/1997 - 19 months male]

Incident 2

We took DECEASED inside. MOTHER was there and I left DECEASED with her. GIRLFRIEND and I grabbed a drink and went to my bedroom to listen to music. We had been there about ten minutes when DECEASED came in and I told him I would take him for another swim in ten minutes. DECEASED went out of my room and I assumed he was with his mum. About ten minutes later I could hear MOTHER calling out DECEASED'S name. MOTHER came into my room and asked me if he was with me. I said that I thought he was with her. [Uncle's statement - 0185/1998 - 3.5 years male]

UNCLE offered to take DECEASED out with him and GIRLFRIEND into the pool. ... When DECEASED came back from being in the pool he still kept nagging me about taking him into the pool. I told him that I wouldn't be long and I would take him into the pool. He went off and played. I thought he went to UNCLE'S room. About three to five minutes later I thought that DECEASED was too quiet. He was a very noisy child and it was unusual for him to be quiet. I went to UNCLE'S room. I knocked on the door thought he was hiding DECEASED in his room. UNCLE insisted that DECEASED wasn't there. [Mother's statement - 0185/1998 - 3.5 years male]
Incident 3

From the evidence presented I find that there was a lack of care from the adults present in relation to the supervision of DECEASED and other young children present. I further find that this lack of supervision has contributed to DECEASED’S death. [Coroner's finding - 3708/1998 - 4 years male]

Incident 4

I told my daughter, who was still watching television that I was going to have a shower and for her to stay there. My son was playing in the lounge room not far from where DAUGHTER was. ... I walked into my bedroom and I unlocked the slide door that accesses the courtyard from my bedroom and I then exited my bedroom and closed the slide door to my bedroom and locked it with a small latch we put on it to keep the kids out of our bedroom. The reason we put latches on the slide door was to keep the kids out of rooms we did not want them in. ... I locked our bedroom slide door with the latch and with my keys in my hand I opened the slide door that accessed the courtyard from the kitchen and I walked through the slide door and locked it with my keys. ... Before I walked out of the kitchen into the courtyard area I checked on DAUGHTER and SON. DAUGHTER was still watching television and SON wasn’t far from the slide door that I just walked out of. I walked into my bedroom through the slide door that accessed the courtyard and I went and had my shower. I don't know how long I was in the shower for but I don’t normally have long showers anyway. [Mother's statement - 1411/1999 - 16 months male]

Incident 5

DECEASED did play in the pool area quite often but generally only when I was out there with him. There is a table by the sliding glass door, inside the house. Sometimes I would sit there and he would play in the pool area. We would talk to each other and I would just watch him. It was not a forbidden area for him but I was always aware when he was there and would watch him. I would never let him out there unless I knew he was there.

I must have let DOG out either during or just after breakfast. I let her out into the pool area via the sliding door from the family room. It was unusual that I let her out there as I usually let her out the back or the front. ... I can't remember whether I locked the door after letting DOG out or not, but I mustn't have, because DECEASED couldn't reach that bolt. I went up to get dressed and make the beds. I came back to make a coffee and then I thought, "I can't hear him". [Grandmother's statement - 3034/1999 - 2 years male]

Incident 6

I went back into the kitchen area, picked DECEASED up and went back to the lounge. I put her on the floor. That was the last place I remember seeing her. I went outside and did some work on the roof. I then came back into the house and spoke to MOTHER about putting a smoke detector in DECEASED’s room. As soon as I had finished installing the detector I collected my tools and went outside to the shed. I came back inside to DECEASED’S room. I closed the sliding door in the lounge as I always did. I went into DECEASED’s room for a short time. When I came out MOTHER was in the kitchen preparing dinner. I asked her where DECEASED was.
We both looked at the family room sliding door and noticed it slightly open. I cannot recall leaving it open. [Father's statement - 3693/1999 - 11 months female]

Incident 7

I do not know how DECEASED got into the pool, we were out the front at the time. The lock on the door is a latch, she was capable of opening it. I did not know that the lock on the gate was faulty. The gates have always slammed shut when you let them go. [Brother-in-law's statement - 3730/1999 - 22 months female]

BROTHER-IN-LAW told BROTHER and SISTER to watch DECEASED as we were going out the front to see SISTER. BROTHER and SISTER were watching the Simpson's on television in the lounge room which is in the same area as the kitchen. ... I would have been outside for about five to seven minutes. We went back inside and BROTHER-IN-LAW asked me where DECEASED was, I said she was probably playing around the house. [Sister's statement - 3730/1999 - 22 months female]

Incident 8

... He kept saying more pool, more pool, more swim, more swim. I got upset with him and sternly told him no, that is enough to for today, no more pool, no more swim. I think I said that Daddy was coming soon, just wait. DECEASED seemed happy with that and he found a computer game on the floor. He came back and sat by my side and played with the game. That was the last I saw of him. I remember getting up with his plastic plate and walking to the kitchen. [Mother's statement - 0147/2000 - 2.5 years male]

Incident 9

HUSBAND and I then went outside and ate our lunch on the front steps. When I left to go out the front to eat, DECEASED was still in the lounge area, where I had put her down earlier. There were plenty of the children around DECEASED to care for her while HUSBAND and I had a quick bite to eat. I have confidence in all my children to care for and supervise DECEASED. They actually loved to care for her and played with her all the time. ... We had decided to discuss some family issues in our bedroom and then have a family meeting later that day. As I walked back into the house and past the kitchen, dining and lounge area, I didn't see any of the children, including DECEASED. I glimpsed down the corridor and saw that SISTER'S bedroom door was shut. I assumed that SISTER and FRIEND had taken DECEASED with them to SISTER'S bedroom. I also remember looking at the back door and it appeared shut. HUSBAND and I went to out bedroom. ... I was writing down some plans for our family. I don't remember what time we went into the bedroom but we were only in there for 20 minutes to half an hour. ... DECEASED was never allowed out of the house unless someone in our family was there to supervise. She was well able to climb the stairs out the back that lead up to the clothes line and barbeque area. I saw her climb down a couple of the back stairs on one occasion. ... I would say she was well advanced in her development. She has also learnt in the last week to get over the ledge of the sliding door. This was only ever done in or someone else's presence. I have ascertained that
SISTER (12) and FRIEND (14) were in the shed in the front yard and walking along the driveway and BROTHER (8) had been with them earlier. BROTHER (14) was downstairs doing some homework on the computer. BROTHER (11) was in room playing on the Sony Playstation. Each of them thought that someone else was looking after DECEASED. [Mother's statement - 0469/2000 - 8 months female]

Incident 10

Everyone was watching her over the course of the weekend and at different stages different people would grab her and stop her getting into mischief. They weren't asked in particular to watch her but everyone was just being helpful. ... When we arrived home FAMILY FRIEND and their kids were in the spa. I went out there with DECEASED to say hello and they were just hopping out. DECEASED of course, wanted to go in but I wouldn't let her. I asked FATHER if he would take her in but he didn't want to as it was too cold. ... DECEASED had been wandering from room to room but at that time I thought she was waiting to have a go on 'the wobbler'. I went to the lounge room and DECEASED wasn't there. I asked AUNT where she was and she told me she had been there a second ago and was next on the machine. ... I was wanting to give DECEASED a bath. I noticed the study door open a little bit and this door is normally closed. I then opened the door and realised the glass sliding door that leads out onto the courtyard where the spa is, was open about 10cm. These doors are normally closed. The sliding door was always locked and dad was always telling everyone to lock it. ... I know that you shouldn't assume that someone is looking out for her but because there was so many adults there and because they'd helped out during the weekend, I thought that she would be with someone. [Mother's statement - 1267/2000 - 20 months female]

Carer Supervision when Child Located Outside House

In the remaining ten cases, the carer was aware that the child was outside at the time of drowning. In seven cases at least one of the carers was also located outside at the time of the incident, three in the immediate pool area. Of the remaining three cases, one carer was inside the house and in the other two cases the location of the carer was not specified. Carers mostly reported being engaged in recreation or social activities at the time of the incident (n=6), two were engaged in home duties and in two cases carer activity was not specified. In 50% of the incidents, the carer reported that the child was left unattended for a period between five and ten minutes (n=5), and in four incidents the time period was estimated to be between ten and 15 minutes. Nearly all carers (n=8) thought that the child was "playing around the yard".

In seven of the ten cases, there was no safety barrier between the pool/spa and the rest of the yard where the child was playing. In two cases the child was located inside the fenced pool area and in the remaining case the child accessed the pool because a section of the fence was missing.

The cases where the child was located outside could be further divided into incidents where the child was playing in the vicinity of the pool and not engaged in water recreation (n=6) and incidents where the child, within a particular time frame, had or was engaged in water recreation (n=4). These are discussed in more detail in the section title Water Recreation.
Excerpts from the coronial file regarding supervision immediately prior to the incident are illustrated below for all ten incidents.

**Incident 1**

I then asked SISTER (11) to go into the house to get a magazine for me to read. I then took my sandals and dress off and started to rub sunscreen on myself. SISTER (11) and SISTER (9) were having a race swimming to the end of the pool. ... My attention was on them and they were having a race to the end. I continued to rub sunscreen on myself as I watched them. DECEASED was on my right with the dog and the girls were in the pool on my left. I saw the girls get to the end of the pool and I continued with the sunscreen. A short time later SISTER (11) said, "Mum!" I looked up and she was out of the pool walking towards me. I looked around for DECEASED and said "Where's DECEASED?" I looked straight at the pool and saw DECEASED in the pool at the bottom he was on the opposite side of the pool to me and the opposite side to when I last saw him playing with the dog. [Mother's statement - 0021/1997 - 4 years male]

**Incident 2**

It would appear that during short period of time DECEASED was not under supervision he has fallen into the pool. There were no witnesses to what occurred. ... It would appear that for the majority of the day adult supervision was adequate, with a short period of inadequate supervision during DECEASED'S disappearance. [coronial finding] // It appears that the adult supervision that day was inadequate for the short time it took for DECEASED to fall into the pool and be located. [Police statement - 0404/1997 - 3 years male]

**Incident 3**

I was outside near my rear shed crushing beer cans. Mother was also outside hanging out the washing and all four of our children were also outside. From where I was crushing cans I could see the twins standing along side the pool at the highest side. As I was crushing cans I had cause to look away every so often. ... After mother sorted out the fighting (of the two older girls) she asked me where DECEASED was. I told her she was with you. MOTHER said that she wasn't. When MOTHER told me she wasn't with her I panicked. [Father's statement - 0496/1997 - 19 months female]

When the washing was finished I took it outside to hang it on the line. When I went out the back the twins were playing with their toys in the driveway. The two older girls had moved out the front. After a while the twins moved across to where FATHER was. FATHER at this time was crushing cans at the rear of the shed. The next thing I remember was seeing DECEASED TWIN BROTHER standing at the side of the pool closest to the fence. I could not see DECEASED. Because of the amount of washing I had on the line I could not see the other side of the pool. I just thought that DECEASED had gone out the front with the other two girls. DECEASED normally chases the older girls when they go out the front because she liked to do what they were doing. [Mother's statement - 0496/1997 - 19 months female]
Incident 4

... I was in the rear yard with DECEASED and my nephew. I was standing next to the trampoline holding onto DECEASED'S hands while he was jumping on the trampoline. While that was happening BROTHER-IN-LAW 1 and BROTHER-IN-LAW 2 were playing kick to kick with the football. I left DECEASED on the trampoline with NEPHEW and went to the western end of the yard and started to play kick to kick with BROTHER-IN-LAW 1 and BROTHER-IN-LAW 1. After a short time BROTHER-IN-LAW 1 left and NEPHEW joined in. I can vaguely remember that DECEASED was following BROTHER-IN-LAW 1 towards the house. The next thing I remember was MOTHER coming out and asking me if I had DECEASED. I replied 'No'. [Father's statement - 0908/1997 - 2.5 years male]

I remember DECEASED saying "bounce me, bounce me", so I went over to the trampoline and put him onto the trampoline and held his hands while he jumped up and down. After a couple of minutes I lifted him off the trampoline and put him on the ground and he then walked away towards the house. I turned around and started playing kick to kick. [Uncle's statement - 0908/1997 - 2.5 years male]

Incident 5

... we had decided to use the pool when our friends and their children arrived that day. Prior to their arrival it was decided to position a table and chairs approximately three metres from the pool so at any time we had adequate vision of the entire pool area and were nearby at all times when children were in or near the pool. I was quite paranoid about the whole thing and didn't feel comfortable about the fence not being erected and the fact that our friends and their children would be around that day. People began to arrive about 11:30 am that morning and as they did we informed them of the situation with the pool and the lack of fencing and advised them to take precautions. One of these precautions was that an adult from every family should be in the pool when their children were swimming. ... By about 6:00 pm that evening the majority of people had left. I was assisting FRIEND, who was in the process of leaving and DECEASED was in my arms, persistently wishing for me to let her go for a swim. I told her to wait until FRIEND had left and then I would take her for a swim. At this time the other children were inside the house. FATHER and FRIEND remained seated at the table beside the pool whilst I walked FRIEND out to her car with DECEASED in my arms. At some time during this process I put DECEASED down and she hopped on her bike and began pedalling around the driveway. ... I was happy for her to remain there (in the driveway) as she knew that the rules were that she was not to go out of the driveway. I then returned to FATHER and FRIEND who were seated at the table beside the pool, checked on their drinks and then went inside the house to get a jug of water and glasses. Whilst inside I checked on the other children and the returned outside. Before sitting down I decided to find DECEASED and see if she still wanted to go for a swim. [Mother's statement - 3805/1998 - 3 years female]

FATHER and FAMILY FRIEND remained at a picnic table about 4-5 metres from the pool edge while MOTHER saw the visitors away. While
sitting at the table they became involved in conversation and were not aware the DECEASED had entered the pool until MOTHER came out from the house and enquired as to where she was. It was at this stage FATHER looked into the pool and saw her on the bottom. [Police summary statement - 3805/1998 - 3 years female]

Incident 6

DECEASED got up and went for a walk with the dogs and he was chatting away to them. He walked along the end of the house and walked towards the dining room sliding door saying "mummy". I told DECEASED that mummy was inside. DECEASED said "puppies inside" and started walking towards the dining room sliding door. I was watching him and put my feet up on the chair. The dogs followed DECEASED as they didn't come back. I lied back on the couch thing and I assumed he had gone inside because the dogs didn't come back. DECEASED could open the back door and walk in so I thought he was going to see his mum. [Family friend's statement - 3167/1999 - 3 years male]

Incident 7

... my mum and MOTHER were talking, they were watching television in the lounge room. We were fixing the cubby house, we had tools to fix it. We asked DECEASED if she wanted to play in the cubby with us a couple of times but she didn't want to. While we were playing in the cubby house, DECEASED was going between us in the cubby house and then going to her mum inside the house, she did this about 5 times. I went inside to tell my mum something and then I saw her floating in the water ... [Family friend's statement - 3447/1999 - 2 years female]

FAMILY FRIEND and I sat in the lounge room. We sat there so we could see the most of the back yard and watch the children play. Most of the children were playing in the cubby house that is right at the back of the house. ... The children were coming in and out of the house. DECEASED was coming in to say hello to me and FAMILY FRIEND. She would then go back out to play. [Mother's statement - 3447/1999 - 2 years female]

Incident 8

He had been out of sight of his parents for up to fifteen minutes. [Coroner's finding - 0113/2000 - 3 years male]

Incident 9

The deceased was at the front of the premises with his mother. The deceased was returned to the rear yard when his mother went inside to feed her six-month-old baby. On the way inside the deceased's mother left the rear door open and told the deceased to come in and have a drink. Five minutes later she heard the deceased cry briefly and thought that his father must have been bringing him inside. Five minutes later the deceased's mother went outside and inquired with the deceased's father and his friends to where the deceased was. [Coroner's finding - 1873/2000 - 2.5 years male]
Incident 10

Father had recently returned home and had sighted the deceased. 10 minutes later father found deceased in the pool. [Coroner's finding - 1873/2000 - 2.5 years male]

Water Recreation

In seven cases the deceased child was either engaged in water recreation at the time of the incident (n=1), had been engaged in water recreation earlier in the day (n=5) or had seen others engaged in water recreation and had requested to do so also (n=1).

Water Recreation at the Time of the Incident (n=1)

The four-year-old male deceased was engaged in water recreation at a premises he was visiting with his mother and three older siblings. The deceased had been wearing a red lifejacket, which he removed because it was uncomfortable, and was then jumping in the pool with a yellow swim ring around his waist. Immediately prior to the incident the deceased got out of the pool and was playing with a dog through the fence at the side of the pool. The deceased's mother was approximately five metres away from the pool, applying sunscreen.

I then took my sandals and dress off and started to rub sunscreen on myself. SISTER (11) and SISTER (9) were having a race swimming to the end of the pool. ... My attention was on them and they were having a race to the end. I continued to rub sunscreen on myself as I watched them. DECEASED was on my right with the dog and the girls were in the pool on my left. I saw the girls get to the end of the pool and I continued with the sunscreen. A short time later SISTER (11) said, "Mum!" I looked up and she was out of the pool walking towards me. I looked around for DECEASED and said "Where's DECEASED?" I looked straight at the pool and saw DECEASED in the pool at the bottom he was on the opposite side of the pool to me and the opposite side to when I last saw him playing with the dog. [Mother's statement - 0021/1997, 4 years male]

The coroner found that the deceased's mother had acted responsibly in requiring the inexperienced young swimmer to enter the pool with an appropriate flotation device, and by remaining present at all times. The coroner was not satisfied that she failed to discharge her onus of supervision, when momentarily distracted whilst applying sunscreen to her body. [0021/1997 - 4 years male]

Water Recreation Prior to the Incident (n=5)

Incident 1

The three-year-old male deceased, who was a visitor to the premises, had played in the pool with his siblings and other children throughout the day with the aid of flotation. At around 8 p.m. that evening, everyone had exited the pool and were gathering around the gazebo. The deceased's father was sitting down the end of the pool under the rotunda and the deceased's mother was organising drinks for the younger children in the gazebo area. During this time the deceased was left unsupervised and was found some minutes later in the pool. The gates had been intentionally left open all day to make access to the pool more convenient and were
later found to be compliant with the applicable regulations (Regulation 5.13). The Coroner made the following comments regarding the safety barrier:

Although the fence was fitted with gates, on this particular day they were left open to make access to the pool more convenient. I believe that under the circumstances the access gate to the pool area should have been closed on the day of DECEASED'S death. If this had been the situation it is possible that the incident would not have occurred.

The coroner also found that for the majority of the day adult supervision was adequate, with a short period of inadequate supervision during the deceased's disappearance. [0404/1997 - 3 years male]

**Incident 2**

In the second incident a three-year-old male child, who was a visitor to the premises, drowned in an above-ground swimming pool. The deceased had been swimming in the pool with his uncle on the morning of the incident and had been nagging his mother and uncle to take him back in and had been told to wait.

UNCLE offered to take DECEASED out with him and GIRLFRIEND into the pool. ... When DECEASED came back from being in the pool he still kept nagging me about taking him into the pool. I told him that I wouldn't be long and I would take him into the pool. He went off and played. I thought he went to UNCLE'S room. About three to five minutes later I thought that DECEASED was too quiet. He was a very noisy child and it was unusual for him to be quiet. I went to UNCLE'S room. I knocked on the door thought he was hiding DECEASED in his room. UNCLE insisted that DECEASED wasn't there. [Mother's statement - 0185/1998, 3 years male]

We took DECEASED inside. MOTHER was there and I left DECEASED with her. GIRLFRIEND and I grabbed a drink and went to my bedroom to listen to music. We had been there about ten minutes when DECEASED came in and I told him I would take him for another swim in ten minutes. DECEASED went out of my room and I assumed he was with his mum. About ten minutes later I could hear MOTHER calling out DECEASED'S name. MOTHER came into my room and asked me if he was with me. I said that I thought he was with her. [Uncle's statement - 0185/1998, 3 years male]

The deceased accessed the pool via the pool gate that had been left open and later found to be non-compliant with the relevant regulations (BCA 97) because it was not self-closing or self-latching. The deceased then accessed the pool via the pool ladder, which was left down. In this case the Coroner found that the deceased's grandparents contributed to the cause of death by failing to comply with the safety barrier legislation and the deceased's uncle for leaving the pool gate open.

**Incident 3**

In the third incident the deceased's parents were in the process of installing a fibreglass swimming pool. It was necessary to partly fill the pool as the soil was packed around the outside in order for the pool to be stabilised. During the preceding two weeks the deceased's father had intermittently back filled around the pool shell
whilst filling the pool with water to the same level as the fill. When he was not doing
this he would place a large reinforced mesh cover across the top of the pool to prevent
anyone gaining access to the pool. On the day of the incident a social gathering of ten
adults and 13 children was held at the premises. It was intended that the fence would
be erected the day before the social gathering, however the unexpected arrival of earth
moving equipment prevented this.

Throughout the day the deceased swam in the pool under supervision and had
requested to re-enter the pool later in the afternoon. The deceased was told to wait ten
minutes by her mother who was saying goodbye to some of the guests.

By about 6:00 pm that evening the majority of people had left. I was
assisting FRIEND, who was in the process of leaving and DECEASED was
in my arms, persistently wishing for me to let her go for a swim. I told her to
wait until FRIEND had left and then I would take her for a swim. At this
time the other children were inside the house. FATHER and FRIEND
remained seated at the table beside the pool whilst I walked FRIEND out to
her car with DECEASED in my arms. At some time during this process I put
DECEASED down and she hopped on her bike and began pedalling around
the driveway. ... I was happy for her to remain there (in the driveway) as she
knew that the rules were that she was not to go out of the driveway. I then
returned to FATHER and FRIEND who were seated at the table beside the
pool, checked on their drinks and then went inside the house to get a jug of
water and glasses. Whilst inside I checked on the other children and the
returned outside. Before sitting down I decided to find DECEASED and see
if she still wanted to go for a swim. [Mother's statement - 3805/1998, 3 years
female]

The deceased's father and a family friend remained at a picnic table about four to five
metres from the pool edge while the deceased's mother saw the visitors away. While
sitting at the table they became involved in conversation and were not aware the
deceased had entered the pool until the deceased's mother came out from the house
and enquired as to the whereabouts of the deceased. The deceased's father looked into
the pool and saw her on the bottom. The coroner found that the deceased's mother and
father contributed to the death.

Incident 4

In the fourth incident a two-year-old male child, who was a visitor to the premises for
a social gathering, drowned in an in-ground swimming pool. The deceased was the
youngest of eight children present at the premises, all of who had been swimming in
the pool throughout the day. At 5:00 pm everyone went inside the premises, where the
deceased had a meal. After the meal the deceased requested to re-enter the pool, but
was told "no" by his mother.

He kept saying more pool, more pool, more swim, more swim. I got upset
with him and sternly told him no, that is enough to for today, no more pool,
no more swim. I think I said that Daddy was coming soon, just wait.
DECEASED seemed happy with that and he found a computer game on the
floor. He came back and sat by my side and played with the game. The was
the last I saw of him. I remember getting up with his plastic plate and
walking to the kitchen. [Mother's statement - 0147/2000, 2 years male]
The deceased exited the house via a sliding door that led to the rear yard and into the pool area via the gate, which had been propped open with a rock. It could not be determined how and when the rock was positioned next to the gate.

**Incident 5**

In the fifth incident a five-year-old male drowned in an in-ground swimming pool, which had been completed two days prior to the incident and filled with water on the day of the incident. The deceased had been swimming in the pool with his siblings earlier in the day but had exited the pool when his father left the premises to buy pool chemicals. Oh his return, the deceased's father sighted the deceased outside the house. Ten minutes later the deceased was located floating in the pool. A safety barrier had not yet been erected around the pool. [3791/2001, 5 years male]

**Watched Others engaged in Water Recreation (n=1)**

The 20-month-old female deceased was visiting her grandparents in rural Victoria and had returned back to the premises with her parents to find other visitors to the house in the spa.

> When we arrived home FAMILY FRIEND and their kids were in the spa. I went out there with DECEASED to say hello and they were just hopping out. DECEASED of course, wanted to go in but I wouldn't let her. I asked FATHER if he would take her in but he didn't want to as it was too cold.  
[Mother's statement - 1267/2000, 20 months female]

The deceased's father was watching television and mother was in the kitchen. The deceased's mother reported that she thought the deceased was in the lounge room waiting for her turn on a toy called "the wobbler". The deceased accessed the spa via a sliding door that was later found not to comply with AS 1926.1. The point of non-compliance on the sliding door was that it was not fitted with a self-latching or self-closing device, and the latch was not located 1.5 metres above the internal ground level.

In all cases where information was available (n=5) the child had communicated a desire to enter or re-enter the swimming pool or had been previously engaged in water recreation. These children were too young to understand the need for them to be assisted or at least supervised in the water. Furthermore, the children were too young to understand the connection between supervised safe water recreation and hazardous unsupervised water recreation. Over-confidence from prior water recreation may also have played a role.