

CITATION: *Inquest into the death of Baby Croker* [2023] NTLC 17

TITLE OF COURT: Coroners Court

JURISDICTION: Darwin

FILE NO(s): D0087/2022

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FINDING OF: Judge Elisabeth Armitage

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Swimming Pool Safety Act 2004

REPRESENTATION:

Counsel Assisting: G O'Brien-Hartcher

Department of Infrastructure,

Planning and Logistics: T Cramp

Department of Health: C Zichy-Woinarski

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IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0087/2022

In the matter of an Inquest into the death of

BABY CROKER

ON: 2 April 2022

AT: Katherine Hospital

FINDINGS

Judge Elisabeth Armitage

Introduction

1. Baby Croker was born in Katherine on 8 June 2019 to parents Ms Kaylia Coolwell and Mr Arnold Croker. Her parents requested that she be called Baby Croker in the inquest.¹ She had an older sister and a younger brother. She was healthy, happy, outgoing, and curious. Fish and watermelon were her favourite foods. She was the chatterbox of the family and always made everyone laugh. Because Peppa Pig was a favourite TV show, she cheekily referred to her parents as Mummy and Daddy Pig. She loved fishing, playing with dolls (Katie and Joy) and most animals (but not dogs), and visiting family in Borroloola. Tragically, she was just two years and 9 months old when she drowned in a private backyard pool in Katherine on 2 April 2022. I extend my deepest sympathy to her family and friends who are devastated and grief stricken.
2. Baby Croker's death was reported to me because it was a death that occurred in the Northern Territory, which was unexpected and was accidental. The decision as to whether to hold an inquest into this death was discretionary. Every weekend in the Northern Territory, families and friends socialise together around private backyard pools. Tragically, Baby Croker drowned

¹ There is a Non-Publication order in respect of the names of all children referred to in the inquest under the age of 18 years, except the deceased may be referred to as 'Baby Croker'

at such a gathering. Baby Croker, her mother and a sibling were at a backyard get-together with several other adults and numerous children. The swimming pool fence gate was propped open so the children had easy access to the pool. When Baby Croker drowned there were several children swimming in the pool but all the adults were outside the pool area and not ‘actively supervising’ the children. In those circumstances the risks to Baby Croker and the other children were not appropriately identified or mitigated by any of the adults present and I determined that a public inquest was warranted.

Childhood drowning –learning from tragedy

3. Tragically, drowning is one of the leading causes of accidental death for Australian children. Nationally, 364 children in the 0-4 age bracket drowned in Australia between 2007 and 2022.² 12 deaths occurred in the Northern Territory and 83 percent of those Northern Territory deaths occurred in home swimming pools.³ ABS data establishes that drowning is the number one causes of death in one-, two- and three-year-old children.⁴ In response to these tragedies there have been numerous inquests and reviews over the last decades which reveal that the majority of these deaths are preventable. Across the investigations recurrent risks have been identified including non-existent or inadequate fencing, gates being propped open, and inadequate adult supervision.
4. For example, on 14 June 1996 Territory Coroner Dr Lowndes published findings concerning the deaths of five children, all under three-years-old, who had drowned in backyard pools in the Northern Territory:⁵
 - a. A two-year-old boy who drowned in a neighbour’s pool in Woodleigh Gardens. The pool gate and pool fencing were faulty and he was unsupervised.

² Data extracted from the Royal Life Saving National Fatal Drowning Database

³ Data extracted from the Royal Life Saving National Fatal Drowning Database; T 9, evidence of Ms Annette Floss Roberts, Executive Director Royal Lifesaving NT

⁴ ABS, Causes of death data, Customised Report, Table 1:Accidental drowning deaths by top 5 leading causes, 0-4 years, Australia, 2014-2018

⁵ *Inquests into the deaths of William Thomas Fletcher, Victor Voules-Brown, Dale Jordan Thomson, Matthew Joseph Murray and Miekayla Jaqueline Guttridge* 14 June 1996

- b. A boy who drowned in his aunt’s pool in Ludmilla just two days before his second birthday. The barriers to the pool were not child-proof and he was unsupervised.
 - c. A boy who had just turned two who drowned in his grandparents’ spa. The gate was faulty and did not close properly and he was unsupervised.
 - d. A boy who had just turned one who drowned in his parents’ spa in Anula. The barrier was not child safe and he was unsupervised.
 - e. A one-year-old girl who drowned in a pool in Nightcliff. The gate was not latched and she was not supervised.
5. On 9 September 2014 the Deputy State Coroner, Brisbane, declined to hold an inquest into the death of a two year old child. In non-inquest findings⁶ she said:

“There is little benefit to be gained by an inquest in these circumstances. While the pool was strictly non-compliant with respect to certain details of the fencing and non-clearance zones, the greatest failing was with respect to the failure to close the pool safety gate which was tied in an open position. ... An inquest is unlikely to make any difference in helping to prevent the deaths of other children occurring in similar circumstances. The greatest risk to non-swimming children remains inadequate adult supervision together with non-compliant fencing and gates, especially allowing gates to be held in an open position.”

6. Two years later an inquest was held concerning the drowning death of a four-year-old.⁷ This investigation indicated that two critical factors may have played a part in the tragic events, namely: a deliberate propping open of the pool gate, which then allowed access to the pool area by other children including [the deceased], and the level of supervision that was provided to the children during that time. It was noted that:

“...the enhanced pool safety and fencing laws that have been introduced into Queensland have been very successful. But deaths

⁶ Ms Christine Clements, Deputy State Coroner Queensland, Non-Inquest findings of the investigation into the death of a two year old child, 9 September 2014

⁷ Mr John Lock, Deputy State Coroner Queensland, Inquest into the death of William Chase Corben, 7 April 2016

have continued to occur because of deliberate breaches of the pool safety laws by placing obstacles in front of gates, which effectively renders useless the safety features intended by pool fencing and compliant gates in the first place.”

7. The *Swimming Pool Safety Act NT* (the Act) came into force in 2004. According to the Second Reading Speech the responsible Minister said that the purpose of the legislation was “to protect our youngest and most vulnerable” and to strike “an effective balance between protecting young children and community acceptance of child water safety responsibility.”⁸ The Act put in place more standardised requirements for pool fencing directed towards protecting unsupervised children under 5 years of age from drowning.⁹ But premises larger than 1.8 hectares were and remain exempt from fencing requirements.
8. In spite of the intent of the legislation, children have continued to drown. Since 2010 there have been more than 240 fatal and non-fatal child drownings reported to emergency departments in public hospitals in the Northern Territory. More than 120 of these incidents occurred in a private pool.¹⁰
9. In 2009 the Deputy State Coroner of New South Wales conducted an inquest into the death of eight children who drowned in residential swimming pools. In findings published on 30 April 2010¹¹ he recommended that the New South Wales Government:
 - develop a media campaign addressing: constant supervision of young children around home swimming pools; the need to ensure pool gates are never propped open; and the requirement for regular maintenance of pool barriers;
 - develop a centralised register of private swimming pools and a **systematic plan for regular review** of all private swimming pools to ensure compliance with safety provisions;
 - **remove all exemptions** of pool fencing requirements;

⁸ Hansard Debates NT Parliament 17 February 2004, at 5868 ff.

⁹ *Swimming Pool Safety Act 2004* ss 4 ‘child’, 11, 12, 35, 37

¹⁰ Data provided by NT Health 2010 – 2022. These statistics likely under-report non-fatal drownings, as non-fatal drownings might not be reported to an emergency department.

¹¹ Magistrate P. A. MacMahon, Deputy State Coroner, NSW State Coroner’s Court, Inquests touching the deaths of “A”, “B”, “C”, “D”, “E”, “F”, “H”, 30 April 2010

- oblige owners of leased properties to take reasonable action to ensure their pools comply with safety provisions, and that at the start of every lease the pool barriers comply with the law;
 - ensure that retailers of above ground pools make owners aware of their safety obligations and that they notify the relevant authority when a pool is delivered to an address.
10. The NSW Drowning Report 2002-2017 examined the circumstances of pool deaths over a 15 year period. The analysis revealed that children under the age of five are at the highest risk of drowning and home swimming pools were the leading location for fatalities. Sadly, in the 15 years covered by the report, 148 children aged 0-4 drowned in NSW. In 63.7% of the drowning deaths supervision was deemed to have been completely absent, and in a further 5.5% of cases children were supervised by siblings or other children. When supervisors were present, deaths commonly occurred when the supervisor was distracted by an everyday event.
11. The same report revealed that 21.4% of pools where children drowned were not fenced, and in a further 39.3% of cases fencing was deemed non-compliant with fencing regulations or was known to be faulty. Children commonly gained access to pools through fences or gates which had fallen into disrepair (38.0%), unfenced pools (26.0%) or through gates deliberately propped open (24.0%).

The Swimming Pool Safety Authority

12. Swimming pool safety barriers in the Northern Territory are regulated by the Act. The Act establishes the Swimming Pool Safety Authority (the Authority), a statutory position currently held by Mr Mark Meldrum. The Pool Fencing Unit sits within the Land Services Unit of the Department of Infrastructure, Planning and Logistics. There are currently 4 swimming pool safety advisers attached to the unit. The Authority is responsible for ensuring compliance with, and prosecuting breaches of, the Act.
13. Under the Act, when a new pool is built on small premises (a property of less than 1.8 hectares) the owner must apply for a compliance certificate. Following one or more inspections, the Authority will issue a compliance certificate when it is satisfied that the pool fencing meets the requirements of the legislation. As discussed earlier, there are no legislated requirements for swimming pools to be fenced on properties of 1.8 hectares or greater.

14. When issued, a compliance certificate is for an indefinite term and there is no requirement for on-going inspections. The Act requires the owner to take personal responsibility for ensuring the fencing remains compliant, that is, in substantially the same condition as on the date the certificate was issued.
15. When a property is sold, the Act requires an acknowledgement notice be issued. There is no physical inspection of the pool by the Authority. The vendor or his/her agent are required to lodge a 'Declaration of Compliance'. The Authority relies on the self-assessment of compliance as declared, and if all the required information is provided, issues the acknowledgement notice which confirms the owner has declared the pool complies with the Community Safety Standard and the owner has applied the Guidelines.¹²
16. When a property is rented the landlord is to ensure the swimming pool is certified and there has been no contravention of the certification, that is, the swimming pool and barrier are in substantially the same condition as when the certificate was granted. Alternatively, the landlord is to submit a 'Declaration of Compliance' and obtain an acknowledgement notice, or obtain a compliance certificate.¹³ Except in circumstances where a compliance certificate is sought, there are no re-inspections and the Authority relies on the self-assessment of the landlord as to compliance.
17. While the Act does not require swimming pool barriers to be re-inspected after a compliance certificate is issued, inspections do occur if the Pool Fencing Unit receives a complaint about non-compliant or dangerous pools, if an owner/occupier requests an inspection, or if it receives a report of a fatal drowning from the Northern Territory Police Force.

The evidence in this matter

18. It is against this background that I heard evidence and submissions over three days from 16 May 2023. The evidence revealed that many factors required for children to be safe around backyard swimming pools were sadly absent on 2 April 2022 when Baby Croker passed away.

¹² *Swimming Pool Safety Act 2004* s 24; *Swimming Pool Safety Regulations 2004* Regulation 6, Schedule 2

¹³ *Swimming Pool Safety Act 2004* s 29

The circumstances of the drowning

19. The gathering was a pre-season football team get-together hosted at a suburban home in Katherine. As seen in the photos below, the property included an elevated house with a carport underneath, which was used for entertaining, and a 5 metre long, cement, in-ground swimming pool in the backyard. The pool gradually sloped from the shallow end to the deep end and there was a lip under the waterline around the edge. The shallow end was closest to the carport. There was a pool fence and gate separating the carport from the pool.
20. The plan for the day was for team members and their children to socialise, swim, eat lunch, and watch a football match. The carport was set up for the event. There was a TV on one wall and under the TV there was a table for food. Chairs were placed loosely in a semi-circle facing the TV and food, and there was a mat on the floor for children to sit on. For ease of movement, the pool gate between the carport and the pool was propped open with a 9 kg gas bottle. A hose was also hung over the gate and the fence. Both items prevented the pool gate from closing.





21. Members of the football team and their children started arriving at about midday and continued to drop in throughout the afternoon. There was only very little BYO alcohol at the event, most of the adults were not drinking, and everyone remained sober. I did not hear from Baby Croker's mother as she was too traumatized to attend the inquest. But the team member who was hosting the event (the host) and lessee of the property, gave evidence and said that Baby Croker arrived with her mother and older sister at about midday.
22. During the afternoon there were approximately 13 adults at the gathering and 11 children, some of whom were swimming. The gate between the carport and the pool remained propped open throughout the event, so the children could move freely between the two areas. Although the adults could see into the pool area, there were no adults physically in the pool with the children or on the pool side of the fence. The adults remained in the carport, watching the pool through the fence, socialising, preparing the food and barbeque, and watching the football.
23. At about 1.30 pm the food was ready and all the children who had been swimming, including Baby Croker, came out of the pool to eat lunch with the adults in the carport.
24. After lunch, the children who were swimming gradually returned to the pool. Baby Croker rested near her mother but later joined other children in the pool. In her statement to police Baby Croker's mother said that while she was talking to a teammate in the carport she saw Baby Croker sitting on the edge of the pool at the shallow end. Although she felt she "didn't take her eyes off the pool", she may have lost concentration and "just gone a bit blank" while talking to her friend.
25. At about 2:30 pm, while the host was dropping her husband to golf and briefly away from the premises, a nine-year-old girl who was swimming, saw Baby Croker under water at the deep end. Another child screamed, "she's drowned." An 11-year-old boy lifted Baby Croker out of the water. She was limp in his arms and unresponsive.
26. Several adults rushed from the carport to the poolside and 000 calls were made at 2.45 pm. The boy handed Baby Croker to one of the adults who was an Aboriginal Health Practitioner and student nurse. She and another guest performed CPR. Her mother was distraught.

27. The police and paramedics arrived within minutes and continued the CPR efforts for 46 minutes at the scene and in the ambulance on the way to hospital. Tragically Baby Croker could not be revived and she was pronounced deceased at Katherine Hospital at 3:37 pm.
28. Following an autopsy on 5 April 2022 the forensic pathologist, Dr Marianne Tiemensma, considered that the cause of death was drowning. There were no other health issues which contributed to Baby Croker's death.
29. On 12 April 2022 the Authority inspected the pool fence. Several faults with the fence and gates were identified. Although not instrumental, the faulty fencing was a preventable risk which forms part of the relevant circumstances connected with the death.

What went wrong?

There was no 'active supervision'

30. Ms Annette "Floss" Roberts, the Executive Director of Royal Life Saving in the Northern Territory, gave evidence. As drowning is often quick and silent she stressed the importance of 'active supervision'. Active supervision means an adult paying attention and within arms-reach of a child who is in the water. Ms Roberts emphasised that this responsibility cannot be delegated to siblings or other children.
31. Some of those present at the event or connected to the premises who gave evidence firmly believed that it was the mother's responsibility to supervise her children. That is no doubt true. However, I do not consider that precludes other adults having joint or shared responsibility for the children in the pool. Common decency points to all the adults, and perhaps particularly the host who invited the children to use the pool, sharing joint responsibility for ensuring all the children were safe and properly supervised. It is a tragedy that although there were many adults at the function, none were actively supervising as described by Ms Roberts, that is, none were: inside the pool fence, or within arms-reach, of any of the children.
32. The witnesses who believed it was primarily the mother's responsibility to supervise her children queried what more they could have done, particularly as they did not wish to be seen to be critical of another parent. However, on deeper reflection, some witnesses agreed that for social gatherings involving a pool there could be a designated adult actively supervising, and

parents/adults could, for example, take turns being the designated active supervisor. Another idea, which Ms Roberts supported, was that invitations to events with pools could remind parents/adults of their responsibility to actively supervise children. Alternatively, there could be clear rules about pool use, for example, ‘no supervisor, no pool’. A clear understanding could be established that the pool was not to be used except when there was an adult actively supervising because, on the evidence of this and previous inquests, the only safe alternative to active supervision in the pool is no children in the pool. Any of these approaches, and no doubt there are others, might have prevented or at least reduced the risk of Baby Croker, or any child, drowning.

The gate was propped open

33. The evidence from this and other inquests clearly established that for a pool fence or barrier to be effective in reducing the risk of drowning it must be child-proof. At its most basic this requires that gates are not propped open so the barrier is intact.
34. The host grew up in the premises and when she was a child her father (the owner/landlord) propped the gate open “every now and then.” In evidence he told me “everybody who owns a pool has done it before, I’ll guarantee you. If they said they haven’t, they’re lying.”
35. Propping open the pool gate was something that continued when the host returned to the property as an adult and leased the property from her parents. As discussed earlier, the pool gate was propped open with a gas bottle and hose on the day that Baby Croker passed away. And seemingly consistent with the owner/landlord’s evidence ‘that everyone does it’, it appears that none of the adults at the gathering objected to, or expressed any concern about, the gate being propped open.
36. It was disturbing to learn that, even after Baby Croker’s death and in circumstances where the host had her own young child living at the premises, there were occasions when the gate was again discovered propped open. It was propped open in April of 2022 when the Authority had arranged to attend and conduct an inspection of the fence. This is particularly concerning because the occupiers were aware the Authority would be attending to inspect the fence, but still left the gate open. The swimming pool safety

adviser reminded the occupiers to shut the gate but took no further action at that time, and did not keep a written record of his observations of the gate.

37. Constable First Class Riley Stone saw the gate propped open with a gas bottle on both 7 and 8 March 2023 and took a photo.

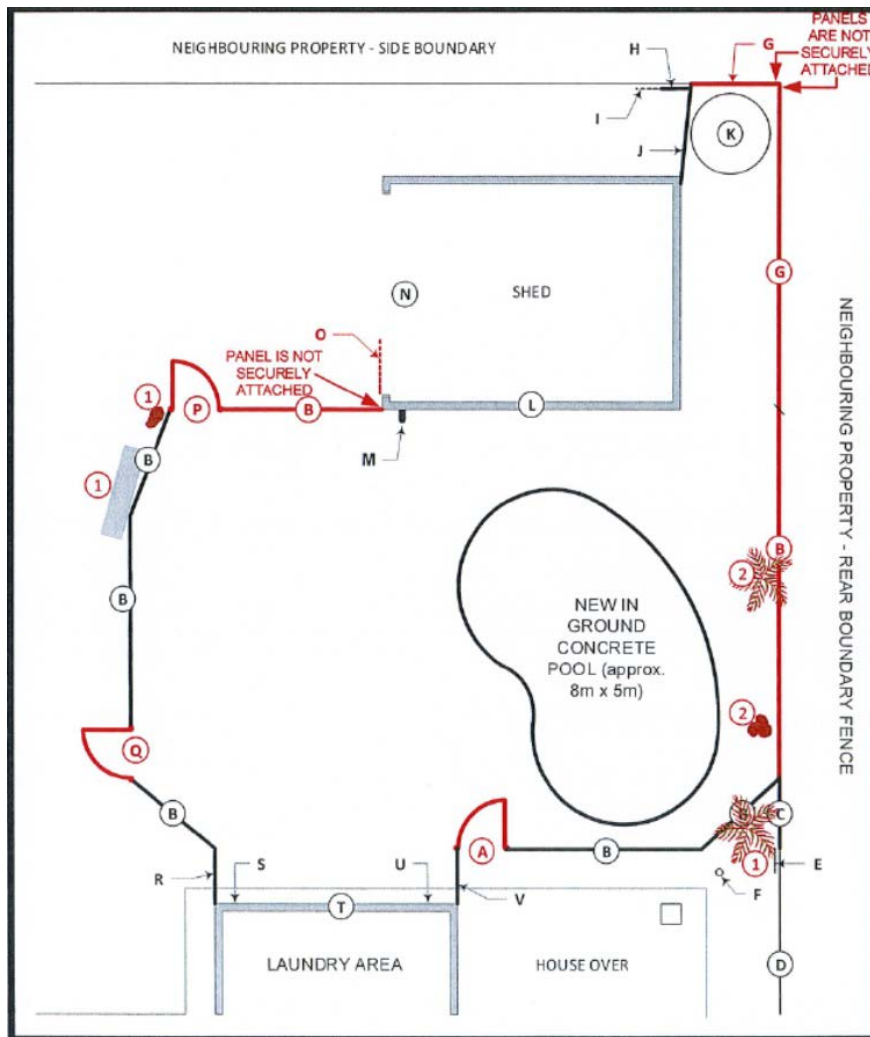


38. As it is an offence under the Act to prop open a pool gate when not in use punishable by a fine,¹⁴ and because the matter was listed for inquest, Constable 1/C Stone wrote to the Authority notifying them of the breaches and providing photos. On receipt of the information, the Authority wrote to the occupiers reminding them of their obligations under the Act, informing them they could be fined for breaches and requesting them to keep the pool gate closed. Apparently the letter made an impact. The host said that it “pulled [her partner] up” and “the gate has not been propped open since.”

The pool fence was non-compliant

39. The original compliance certificate for the pool was issued on 9 February 2007. The next inspection occurred after the police contacted the Authority about the drowning. The inspection on 12 April 2022 found that the pool barrier/fence had not been adequately maintained and was not compliant with the legislation. Many of the faults, identified in the diagram and listed below, appeared to have been longstanding.

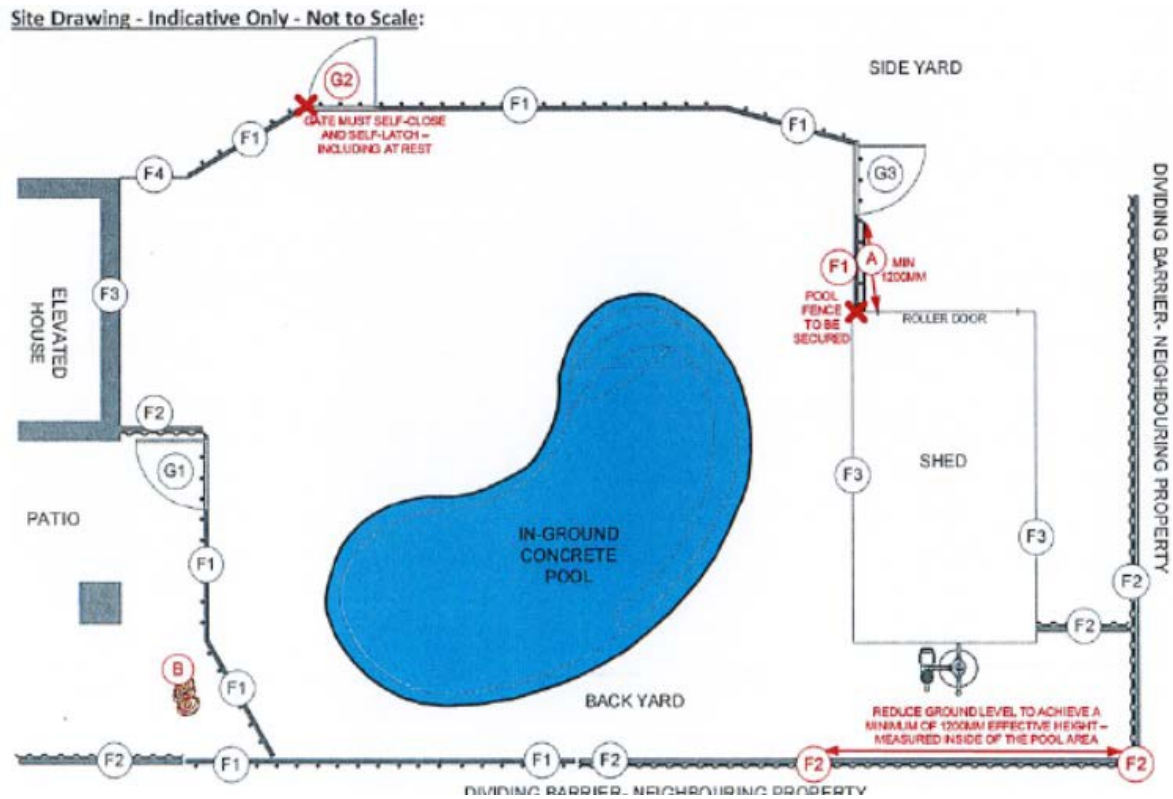
¹⁴ Section 33 *Swimming Pool Safety Act 2004*



- A. Single gate is required to self-close and self-latch (from all positions) including at rest.
- B. Pool fence is required to measure a minimum effective height of 1200mm from the finished ground level. Ground build up has reduced the effective height and is required to be removed. Pool fence panel is loose and is required to be securely fixed.
- G. Pool fence is required to measure a minimum effective height of 1200mm from the finished ground level. Ground build up has reduced the effective height and is required to be removed. Pool fence panels are loose and are required to be securely fixed.
- O. Shed roller door has indentations greater than 10mm and is located within 1200mm to the pool fence. Shielding that was installed in front of the shed roller door is required to be reinstated.
- P. Single gate is required to self-close and self-latch (from all positions) including at rest.
- Q. Single gate is required to self-close and self-latch (from all positions) including at rest.
- 1. Various items (Palm tree stumps/suckers, camping equipment, rock) are located within the 1200mm clear-span from the outside top of the pool fence and are required to be removed or pruned.
- 2. Palm tree and tree stumps are located within 300mm of the inside of the pool fence and are required to be removed.

40. The owner/landlord was advised of the matters that required rectification by email dated 14 April 2022. He was advised that rectification should occur as a priority and he should arrange a re-inspection within the following 30 days. In spite of the advised 30 day period, the next inspection did not occur until

17 August 2022. That second inspection revealed that several issues were still outstanding as indicated on the diagram below.



41. In the end it took seven months for the problems with the fence to be rectified by the owner. After a third inspection, a new certificate of compliance was finally issued on 18 November 2022. Mr Meldrum conceded that 7 months was too long for the pool to have been inadequately fenced.
42. During the period of identified non-compliance, there was a toddler living at the premises and the pool remained full of water. The issues of non-compliance included gates that were not self-closing and potential climbing points that might have enabled access. According to the fencing standards required by the Act, the fence was not child-proof. Although, there is a power to order that a pool be drained, Mr Meldrum said that it was used “very infrequently” in high risk circumstances. In this instance the owner/landlord was not directed to drain the pool. It is not easily understood how the level of non-compliance coupled with a toddler on the premises was not considered sufficiently risky to require the pool to be drained. I also wonder whether the fence might have been made compliant in a more timely fashion had there been a direction to drain the pool.

43. Neither the host nor the owner/landlord seemed well informed of their respective obligations under the Act, even after the drowning. The owner/landlord said he was unaware of his obligations when he rented the property and, as he was not an expert, he relied on the post-drowning inspection to alert him to the problems with the fencing. He conceded he had become blasé about the pool fence and thought that other pool owners were likely blasé as well. I consider it probable that his attitudes are indicative of attitudes held in the wider community.

What can be done better to prevent future deaths?

Regular pool fence inspections

44. Mr Meldrum estimated there were in excess of 17,000 certificates issued for private pools in the Northern Territory. Given there are pools that had certificates issued up to 20 years ago, Mr Meldrum frankly conceded that he could not be confident those pools remained compliant with the requirements of the Act, even when Declarations of Compliance were received.
45. Mr Meldrum's lack of confidence in the levels of compliance with the Act appears consistent with the limited evidence available on the issue. I understand that normally no statistical analysis is undertaken, but for the purposes of this inquest the Pool Fencing Unit conducted a small study. Twenty (20) swimming pools that had been inspected in 2021/22 were randomly selected. Of those 20 pools, 75% (15) were non-compliant with the Act and required further inspections and advice before compliance was reached and a certificate could be issued. The 25% (5) of pools which were compliant on first inspection were all newly constructed.
46. Natural changes to the landscape occur over time and often negatively impact compliance. In addition, fencing succumbs to wear, tear and age, such that it requires considerable diligence on the part of all pool owners to ensure that compliance is maintained. Against likely high levels of degradation due to the climatic factors in the Northern Territory, it is simply not known how many owners are ignorant of the law or become blasé and fail to maintain their pool barriers as required.
47. Fencing requirements are technical and site specific. It often takes several inspections before a pool fence is deemed compliant and a certificate is issued. In those circumstances, I question the capacity of well-intentioned yet untrained lay persons who own or occupy premises to understand and

stringently apply the fencing requirements. As the owner/landlord said, expecting owners to police their own pool fence compliance was like “writing out your own roadworthy certificate for your car.” Compared to self-assessment, he thought regular inspections was a “brilliant idea”, because “they’re the experts ...and know all the ins and outs of what needs to be done.”

48. Scepticism as to the reliability of self-assessment increases when there is a conflict of interest. Owners keen to secure a sale or lease have a significant interest in assessing their premises as compliant, especially when the alternative may result in lost opportunity, delay, expense, and/or a perceived loss of amenity in their property. The same applies to keen purchasers.¹⁵ As for rentals, tenants might naturally feel conflicted and be reluctant to complain to landlords about issues of fence maintenance and repair, as required under the Act,¹⁶ especially when the rental market is tight and properties are hard to find.
49. In the Australian Water Safety Strategy 2030 the 0-4 age bracket is a priority focus. The Australian Strategy specifically supports inspection regimes, swimming pool registers and the proactive implementation of pool inspection systems by Government authorities.¹⁷ But there is no parallel commitment expressed in the Northern Territory Water Safety Strategy 2017-21.
50. In order to overcome the obvious pitfalls of a system reliant on pool owners exercising informed and diligent personal responsibility, consistent with recommendations in other inquests and reviews, a number of jurisdictions have moved to regular pool fence inspection regimes. In Victoria and Western Australia pool fencing inspections are carried out every four years. The Australian Capital Territory is proposing an inspection every 5 years. In Queensland inspections must be carried out for the sale of a property.
51. Mr Meldrum said that he would have a “lot more confidence in compliance... if we did the inspections ourselves and did not rely on statements and declarations.” There is force in his assessment of the situation. It was his view that given the climatic conditions experienced in the Northern Territory

¹⁵ See for example *Swimming Pool Safety Act 2004* ss 20, 24 and 25.

¹⁶ *Swimming Pool Safety Act 2004* s 34

¹⁷ Australian Water Safety Strategy 2030 p16

inspections every 3-4 years, and/or when a property was sold or leased, would be reasonable.

A more robust approach to enforcing pool fencing requirements

52. Although the Authority has the power to enforce compliance with the Act by prosecuting breaches of the Act, since 2016 there have been no prosecutions for offences under the Act.¹⁸ This is so even though the Authority identifies approximately 10 dangerous pools a year.¹⁹ The Authority has no policy or guidelines in place to guide it on exercising its enforcement powers.²⁰ Further, the police do not investigate or enforce breaches of the Act,²¹ save for reporting pool drownings to the Authority pursuant to their General Orders.²²
53. While the highest penalty for breaches of the Act by individuals is a fine of 100 penalty units²³ and 20 penalty units (or 12 months imprisonment)²⁴ respectively, most offences carry a maximum fine of 10 penalty units or less.²⁵ When Baby Croker passed away a penalty unit was \$162, so the maximum fine for most offences under the Act, for example propping open the pool gate,²⁶ was \$1,620. The Authority is not able to issue on the spot fines and must commence a prosecution to exercise its powers of enforcement within 6 months. The expense, time, and urgency required to commence and prosecute proceedings through the Local Court likely discourages the Authority using its powers of enforcement, particularly when weighed against the available penalties.
54. Pursuant to s 37 of the Act, the Authority has the power to issue enforceable orders directing persons to take specified measures, within a specified reasonable time, to ensure compliance with a provision of the Act. However it seems that the Authority is choosing not to issue enforceable orders. Rather, as was done in this case concerning both the non-compliant fence

¹⁸ T 90 Mr Mark Meldrum. It is not known if there were any before 2016

¹⁹ T 93 Mr Mark Meldrum, and it is not known “how many unapproved pools there would be”

²⁰ T 91 Mr Mark Meldrum

²¹ Affidavit Acting Assistant Commissioner Kylie Anderson 18 April 2023

²² General Order Crime (Homicide and Serious) Investigation

²³ *Swimming Pool Safety Act 2004* s 23

²⁴ *Swimming Pool Safety Act 2004* s 55

²⁵ *Swimming Pool Safety Act 2004* ss 14, 15, 16, 26, 27, 29, 30, 31, 32, 33, 34, 35, 37, 43. See also Regulations 14 and 15

²⁶ *Swimming Pool Safety Act 2004* s 33

and repeated instances of ‘gate-propping’, the Authority wrote to the occupiers and took an educative rather than an enforcement stance.

55. Finally, as discussed earlier, the Authority rarely uses its powers to order that a pool be drained and did not do so in this case, even though the fence was not compliant for over 7 months and there was a young child in a high risk age bracket living at the premises.
56. Whilst the Authority ought not be discouraged from seeking to educate home owners on their responsibilities, based on the limited evidence available (that is, 75% of pools potentially currently non-compliant) it seems a more rigorous approach to enforcement may be required.
57. Giving the Authority the power to issue penalty infringement notices (effectively on the spot fines) instead of having to commence court proceedings might assist the Authority to more effectively enforce the Act. Consideration could also be given to reviewing and potentially increasing existing penalties and extending the time within which prosecutions can be commenced.

Investigate non-fatal drownings, as these incidents are opportunities to identify and mitigate risks and prevent future deaths

58. In his 1996 inquest into the deaths of toddlers in private pools Dr Lowndes recommended that an:

“...independent, qualified monitoring body be established to collect data in respect of all drownings and near drownings²⁷ in the Northern Territory. The information obtained from near drownings can be as useful as the information obtained from actual drownings. It might be considered appropriate for St John Ambulance, hospitals, police and other persons or bodies attending near drownings to develop protocols for the purposes of providing the proposed independent monitoring body with the relevant information. A register would be kept by the proposed body to enable it to review...fencing and other factors relating to safety in private swimming pools.”

²⁷ ‘Fatal drowning’ and ‘non-fatal drowning’ are the currently preferred terminology for ‘drowning’ and ‘near drowning’ respectively – e.g. see Northern Territory Water Safety Strategy 2017-21, Non-Fatal Drowning: acknowledging the full burden of drowning

59. However, evidence in this inquest indicated that the only agency collecting information on non-fatal drownings is the Department of Health, and that information is limited to those persons presenting to an emergency department in a public hospital. There are no systems in place for the Department of Health to collect this information from primary health care centres or clinics. There was no evidence to suggest that any other bodies or agencies, such as Aboriginal run health care agencies, General Practitioners, St John Ambulance, CareFlight or the Royal Flying Doctor Service, were collecting this information. Further, there is no system for reporting non-fatal drownings to an external body, and they are not currently reported to the Authority.
60. Statistically, there are many more non-fatal drowning incidents as compared to fatal drowning incidents. The national ratio of fatal to non-fatal drownings for children aged 0-4 years is 1:8.²⁸ In the Northern Territory the majority of non-fatal drowning incidents occur in swimming pools and the great majority are children under the age of 5.²⁹ However, as incidents of non-fatal pool drownings are not currently reported to the Authority (or any other investigative body), this represents a missed opportunity to investigate the causes of those incidents and to potentially identify any issues of fencing non-compliance or other issues of non-compliance with the Act, or any other risk factors, and pursue rectification.
61. The importance of learning from non-fatal drownings is recognised in the Australian Water Safety Strategy 2030 with one of the key activities for 2021-25 being the investigation of fatal and non-fatal drownings to identify trends and emerging issues.³⁰
62. All parties to the inquest agreed that the reporting of non-fatal child pool drownings to the Authority could assist in preventing or minimising the risk of death to children. The data might assist the Authority to identify trends of non-compliance which could then be addressed, and through follow-up inspections and investigation, improve compliance with the Act. Although a complete data set is not currently collected, the Department of Health submitted that the use of hospital data is consistent with the best practice

²⁸ Australian Water Safety Strategy 2030 p 16, data relates to 2002/03 to 2014/15

²⁹ Steven Skov and Meredith Nielson, *Water related Injury Hospitalisations in the Northern Territory 2001 to 2011*, The Northern Territory Disease Control Bulletin Vol. 21, No. 4 December 2014

³⁰ Australian Water Safety Strategy 2030 p17

approach adopted to non-fatal drowning data. Further, on preliminary advice, the Department of Health considered that the proposed information sharing could be carried out pursuant to the *Information Act 2002*.

Continue to educate

63. Both Mr Meldrum and Ms Roberts emphasised the need for continuing public education about how to keep children safe around pools.
64. Ms Roberts said that wider access to, and greater reach of, the Water Safety Awareness program, which teaches parents about the dangers of pools and active supervision, would be beneficial in mitigating the risks of child drowning. However, only about 12% of children under 4 years of age had participated in the program run in Katherine over the last several years.³¹ That level of participation is far short of the annual target of 2000 enrolments and 75% completion set in the Northern Territory Water Safety Strategy 2017-21.³² Sadly, Baby Croker was one of the 88% of Katherine children (and their parents) who missed out on participating in such a program. And, although Royal Life Saving and other safety bodies attend the Katherine show each year to raise awareness of the program, the host (who has a young child and would be eligible to participate in such a program) said that she was not aware of, and had not attended, any water safety programs running in Katherine.
65. While the Northern Territory Water Safety Strategy 2017-21 places emphasis on improving community awareness and water safety skills, it is concerning that a publically available evaluation of the implementation of the strategy could not be located, and that there has been no update to the strategy since 2021.
66. However, I was encouraged to hear that the Authority is committed to undertaking a quarterly education campaign. The Authority intends to partner with the other key stakeholders that make up the Water Safety Advisory Council to ensure safety messaging is consistent and clear across stakeholders.

³¹ T 16, evidence of Ms Roberts; Royal Life Saving NT statistics, Participation in the NT Water Safety Awareness Program 2015-2023

³² Northern Territory Water Safety Strategy 2017-21, Priority Area 1- Improving Community Awareness and Water Safety Skills, Strategic Goal 2, Reduce drowning deaths in children aged 0-17 years

Strengthen current laws by removing exemptions and applying Australian standards

67. Non-inquest coronial findings were published on 14 November 2016.³³ A three-year-old boy drowned in an unfenced plunge pool on a ‘large property’ exempt from fencing requirements. In those findings the then Deputy Coroner said:

“It was a very sad and tragic accident and it illustrates just how very easy it is for young children to drown.

Children require active supervision at all times when they are playing or swimming in or around the water. Death from drowning can occur in minutes and in most cases supervision is absent for as little as 2-5 minutes. Drowning often occurs without sound, not even splashing.

It is easy to move to blame. However, it is difficult to see apportioning of blame as a productive exercise. The fact is that many a carer or parent has turned his or her back for a moment, whether it is in the house, the yard or a shopping centre and the child has disappeared.

The problem is that there is only one system. It is ‘supervision’. If that fails there is no further system between that failure and potential disaster. That was the issue that the Swimming Pool Fencing Act sought to rectify.

Currently under the Swimming Pool Safety Act 2004, swimming pools located on premises of 1.8 hectares or more in area (‘large premises’) are not required to be fenced.

The Coroner’s Office wrote to the Swimming Pool Safety Authority (Authority) to determine the policy basis for the exemption of properties over 1.8 hectares. The Authority is positioned within the Northern Territory Government Department of Infrastructure.

The Authority indicated that the legislation commenced on 1 January 2003, and was reviewed 12 months after coming into operation. One of the amendments following the review re-defined “large premises” to be premises of 1.8 hectares or more in area (previously defined as being 2 hectares).

It seems that the reason for the exemption of properties over a certain size was that states like NSW had such an exemption.

³³ Mr Kelvin Currie, Deputy Coroner, Coroner’s reasons for decision not to hold inquest, Rel No D0009/2016, 14 November 2016

The Authority's response indicates that no further review has occurred in the last decade.

If there is an appropriate reason for such exemptions it is assumed they relate to the likelihood of streams and dams on larger working properties. However that is a completely different type of hazard to a pool situated within metres of the house. Allowing that hazard to exist, where the property is rented as a residence, also seems somewhat inconsistent with the intent of the legislation.

Recommendation

I recommend that the Northern Territory Government give consideration to the breadth of the exemption from the fencing requirements for pools on properties over 1.8 hectares."

68. In response to that recommendation, the CEO of the Department of Infrastructure, Planning and Logistics undertook to review the *Swimming Pool Safety Act*, and consider all aspects of the current legislation, including whether it is appropriate to extend the requirement for compulsory pool barriers to properties with areas of 1.8 hectares or more. The exemption remains.³⁴

69. In her evidence, Ms Roberts expressed opinions as to the adequacy of current Northern Territory laws to mitigate risk of a child drowning in a private pool. She said:

*"...pool fencing legislation isn't set and forget. ...If we are going to look at what's best practice it is probably Victoria because they've got the most recently updated legislation. It's pretty sad that you have to change legislation based on drowning deaths, particularly children. So it's time to say no more exemptions. A home swimming pool is a home swimming pool...it's time to remove the exemptions and it's also time to upgrade from a community standard to the Australian standard...The community standard was a good start but there are Australian standards and to me that makes sense."*³⁵

70. Mr Meldrum was of the opinion that an unfenced pool was a dangerous pool and all pools associated with dwellings should be safely fenced. He made no exception for pools on large properties.

³⁴ The last amendment to the act was amendment no 8 2016 and concerning forms

³⁵ T 10 Ms Annette Floss Roberts

71. It is obvious that an unfenced private pool, which is designed to be an attractive swimming feature, poses the same risk to children whether it is located on a small or large property. From the perspective of risk, there is no discernible justification for pools not to be properly fenced based on the size of the property.

Conclusion

72. The Royal Life Saving Keep Watch program has been providing advice to Australian parents and carers on how to keep their children safe in and around water. Keep Watch aims to keep children aged 0-4 years safe from drowning by teaching four simple actions:

- (1) **Supervise.** Actively supervise children around water.
- (2) **Restrict.** Restrict children's access to water.
- (3) **Teach.** Teach children water safety skills.
- (4) **Respond.** Learn how to respond in the case of emergency.

Their efforts are to be commended. When pools are properly fenced and children are supervised the risk of death is minimized.

73. But we failed Baby Croker. Sadly the necessary measures to keep her safe were not in place the day she drowned.

74. Baby Croker's mother had not attended a Water Safety Awareness program and likely did not have the education she needed to fully understand what was necessary to keep Baby Croker safe, in particular, the need for active supervision. Only about 12% of children (and their parents or carers) in Katherine have attended such a program over the last few years. That is not good enough and is far short of the target identified in the Northern Territory Water Safety Strategy 2017-2021. Similarly to Baby Croker's mother, other adults present also failed to recognise and mitigate the risk.

75. The pool barrier was inadequate because the gate was propped open, and the barrier did not comply with the Act. It is likely that many pool owners are either not aware of and/or are not diligently upholding their pool fencing obligations. Based on the limited evidence available, it may be that around 75% of private pools are not fenced to the standard required by the Act and some private pools are not required to be fenced at all.

76. The evidence indicated that the *Swimming Pool Safety Act 2004* does not reflect current best practice, and is minimally enforced. The Authority is currently missing the opportunity to learn from non-fatal drownings.

77. Baby Croker, and all our children, deserve better.

Formal Findings

78. Pursuant to section 34 of the *Coroners Act 1993*, I find as follows:

- (1) The full name of the deceased is suppressed but will be provided separately to Births, Deaths and Marriages.
- (2) The time of death was 3.37 pm on 2 April 2022 at Katherine Hospital.
- (3) The cause of death was accidental drowning.

Recommendations

79. The Northern Territory Government ensure that the *Swimming Pool Safety Act 2004* incorporates best practice to appropriately mitigate risks arising from private pools, and should consider: the adequacy of current penalties, the adequacy of the current pool fencing standards, the removal of exemptions, and the implementation of a scheme for regular pool fence inspections.

80. The Swimming Pool Safety Authority appropriately mitigate risks arising from private pools by establishing policies and guidelines concerning enforcement, and enforce the provisions of the Act when appropriate.

81. The Department of Health assist the Swimming Pool Safety Authority to appropriately mitigate risks arising from private pools by taking all reasonable steps to ensure the Authority receives and has data on all non-fatal swimming pool drowning presentations by children at public hospitals in the NT to facilitate the Authority's investigation, compliance and enforcement of the provisions of the Act.

82. The Northern Territory Government ensure the Northern Territory Water Safety Strategy is updated and includes strategies for best practice risk mitigation in respect of private pools.

Dated this 21st day of September 2023.

ELISABETH ARMITAGE
TERRITORY CORONER