IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 0761

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**PAUL DANIEL RAYUDU**
Delivered on:	**18 AUGUST 2016**
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006
Hearing dates:	18, 19, 20, 21 and 22 May 2015 and 17 July 2015
Counsel assisting the Coroner:	Leading Senior Constable Stuart Hastings
Representation	Mr Stephen Russell of Counsel on behalf of Belgravia Leisure Pty Ltd Mr F. Scully of Counsel on behalf of Banyule City Council Mr A. Imrie of Counsel on behalf of the Victorian WorkCover Authority (WorkSafe)[1] Mr T. Fitzpatrick of Counsel on behalf of Mr Timothy Chong Mr R. O'Neil of Counsel on behalf of Mr Luke De Pasquale Mrs M. Ray of Counsel on behalf of Mr Gary Cole and Mr Drew Hildebrand

[1] On Tuesday 19 May 2014 Mr Imrie on behalf of WorkSafe sought leave to be excused from the remainder of the Inquest. The application was granted.

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I, AUDREY JAMIESON, Coroner having investigated the death of PAUL DANIEL RAYUDU

AND having held an inquest in relation to this death on 18, 19, 20, 21 and 22 May 2015 and 17 July 2015

at Southbank

find that the identity of the deceased was PAUL DANIEL RAYUDU

born on 24 April 1991

and the death occurred on 8 February 2014

at the Austin Hospital, 145 Studley Rd, Heidelberg VIC 3084

from:

1 (a) HYPOXIC ISCHAEMIC ENCEPHALOPATHY IN THE SETTING OF IMMERSION

in the following summary of circumstances:

1. On 2 February 2014 Paul Daniel Rayudu was located at the bottom of the 50 metre pool at WaterMarc Aquatic Leisure Centre, a public swimming pool in Greensborough operated by Belgravia Leisure Pty Ltd. He was unconscious when pulled from the water. Cardio-pulmonary resuscitation (CPR) was initiated and he was transferred by ambulance to the Austin Hospital Emergency Department. He was admitted to the Intensive Care Unit (ICU) but failed to improve. Paul Daniel Rayudu died on 8 February 2014.

BACKGROUND CIRCUMSTANCES

2. Paul Daniel Rayudu[2] was 23 years of age at the time of his death. He was an Indian national and arrived in Australia on a student visa on 10 February 2012. Paul had completed a Bachelor of Technology in Pradesh, India and was hoping to complete a Masters degree in Victoria. He was enrolled and studying computer science subjects at Latrobe University.

3. In February 2012, Paul met Virajitha Kelangi (**Ms Kelangi**) on Facebook. Ms Kelangi was also a student from India and also studying at Latrobe University. Paul and Ms Kelangi soon discovered they had many things in common and became friends. In March 2013, Paul and Ms Kelangi became boyfriend/girlfriend[3] and in August 2013 they commenced co-habitating in a house in Bundoora. In October 2013, the couple moved into a unit in Hawker Avenue, Preston.

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[2] During the course of the Inquest Paul Daniel Rayudu was referred to as Paul save for Ms Kelangi who referred to him as Daniel. For consistency, I have, in most part, avoided formality and also referred to him only as Paul throughout the Finding.

[3] Exhibit 1 – Statement of Virajitha Kelangi dated 17 February 2014.

SURROUNDING CIRCUMSTANCES

4. On Sunday 2 February 2014, Paul and Ms Kelangi attended church in Richmond, followed by a take-away meal for lunch, before attending at Latrobe University in Bundoora to study. While at the university, they decided to try to find a waterslide, as it was a very hot day. By 3.00 pm, the temperature had risen to 29.9°C. Ms Kelangi searched the internet and identified the WaterMarc Aquatic Leisure Centre (**WaterMarc**) located at 1 Flintoff Street, Greensborough as having a waterslide and that it remained open until 8.00 pm. Before going to WaterMarc, Paul and Ms Kelangi left the university, returned home to get some additional clothes, purchased chicken rolls at an Indian grocer and went to K-Mart to purchase shorts for Ms Kelangi as she did not have any bathers. On their arrival at WaterMarc, Paul parked his car in the car park underneath the building and the couple walked up the stairs to the reception area. They requested entrance to the waterslide but were advised that it had been closed. Paul and Ms Kelangi decided to enter although they had not originally planned on using the pools, just the waterslide. They paid the entrance fee and went to the change rooms to change into their swimming clothes. They then left their belongings on the tiered concrete steps/seating on the north-west side of the "big pool"[4] before going to the other side of the 50 metre pool which Ms Kelangi recalled was divided into two and that each side of the division also had ropes in them. Ms Kelangi stated that the pool was crowded; '*there was a lot of people there*'.[5]

5. Paul and Ms Kelangi entered the 50 metre pool via a ramp that leads into the shallow end of the pool. The couple initially walked through the water by holding onto the edge of the pool. Ms Kelangi stated:

> *After some time we felt confident and our legs were touching the ground and we thought it was okay we can manage without any support, without holding anything. We moved towards the middle of the shallow end.*[6]

6. At around this time, approximately 7.10 pm and from this position in the middle of the shallow end, Ms Kelangi recalled that one male and one female started winding the ropes in from the shallow end of the pool. When the ropes were removed Paul said that he wanted to do some swimming. He then swam from the middle of the pool to the side and then back to Ms Kelangi, who had remained standing in the middle of the pool.[7] In this position, the water level was up to Paul's shoulders and Ms Kelangi's chin. Thereafter the couple remained close to each other

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[4] The "big pool" is the 50 metre pool at WaterMarc.

[5] Exhibit 1 – Statement of Virajitha Kelangi dated 17 February 2014, T @ p 12.

[6] Exhibit 1 – Statement of Virajitha Kelangi dated 17 February 2014, T @ p 11.

[7] T @ p 12.

around the middle of the shallow end of the pool and were enjoying themselves; frolicking and splashing each other.[8]

7. After the ropes had been removed from the 50 metre pool, the boom[9] dividing the pool into two was returned to the deep end of the 50 metre pool by two lifeguards, one on either side of the pool, by turning wheel-like structures in unison. Once the boom was moved away from the middle of the 50 metre pool, a "drop off zone" from the shallow to the deep end of the pool was created.

8. At approximately 7.30pm Ms Kelangi was found by other patrons floating face down in the 50 metre pool near the drop off zone. She was pulled from the water. No lifesaving guard was nearby so patrons waved and shouted to attract attention. The two lifeguards supervising the closely located leisure pool were the first to notice the activity and calls for assistance around the 50 metre pool, and ran over to provide assistance. Cardio-pulmonary resuscitation (CPR) was initiated.

9. At around the same time, patrons noticed Paul on the bottom of the pool. He was pulled from the water and CPR was commenced. Emergency services were contacted.[10] Members of the Metropolitan Fire Brigade (MFB) were the first responders to arrive at WaterMarc, followed shortly thereafter by Ambulance paramedics. Police also attended. CPR was maintained by emergency services personnel prior to transporting both Paul and Ms Kelangi by ambulance to the Austin Hospital.

10. On arrival at the Austin Hospital Emergency Department (ED), Paul was initially in asystole but a cardiac output was restored. He was intubated, sedated and transferred to the Intensive Care Unit (ICU). Paul's condition failed to improve despite active treatment and on 3 February 2014, a computed tomography (CT) scan of his brain showed cerebral oedema with loss of grey/white differentiation. A neurosurgical opinion was obtained, but considered there was no indication for surgical intervention, given the severity of his condition and likely prognosis. He continued to deteriorate and a neurology opinion on 8 February 2014 noted a poor prognosis with negligible chance of meaningful functional recovery. Following consultation with Paul's family, he was extubated at 10.25pm and was declared deceased at 10.38pm on 8 February 2014.

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[8] T @ p 11.

[9] See paragraph 41 for a description of the boom.

[10] The Events Chronology for emergency services indicate that the 000 call was made at 7.28pm – Exhibit 34 – Inquest Brief @ pp 216, 227, 233.

11. Ms Kelangi was also initially admitted to the ICU at the Austin Hospital but later transferred to a general medical ward before being discharged from the hospital on 10 February 2014. Ms Kelangi made a full recovery.

JURISDICTION

12. Paul's death was determined to be a reportable death under section 4 of the *Coroners Act 2008*, because it occurred in Victoria and appeared to have been unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury.
13. The e-Medical Deposition Form completed by Dr Maysana Allaf, HMO 2 at the Austin Hospital, ascribed the possible cause of Paul's death to *cardio-respiratory arrest as a result of severe hypoxic ischaemic encephalopathy.* Dr Allaf also indicated within the form that the issues to be addressed by the forensic pathologist were *drowning accident which occurred in public pool.*

PURPOSE OF THE CORONIAL INVESTIGATION

14. The Coroners Court of Victoria is an inquisitorial jurisdiction.[11] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[12] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[13] The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the 'prevention' role.[14] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of

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[11] Section 89(4) *Coroners Act 2008*.
[12] Section 67(1) of the *Coroners Act 2008*.
[13] This is the effect of the authorities - see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).
[14] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, in contrast to the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[15] These are effectively the vehicles by which the prevention role may be advanced.[16] It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

15. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

16. Paul's identity was not in dispute, he was not a person placed in "*custody or care*" as defined by section 3 of the Act and his death was not considered to be a homicide. Therefore, it was not mandatory to conduct an inquest into the circumstances of his death. However, I exercised my discretion, pursuant to section 52(1) of the Act, to hold an inquest because I had identified matters of public health and safety that required further investigation. This finding draws on the totality of the material; the product of the coronial investigation of Paul's death. That is, the court records maintained during the coronial investigation, the Inquest brief and the evidence obtained at the Inquest, including submissions of legal counsel and counsel assisting.

17. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

STANDARD OF PROOF

18. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[17] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the

[15] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.
[16] See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[17] (1938) 60 CLR 336.

evidence, I should bear in mind:

- the nature and consequence of the facts to be proved;
- the seriousness of an allegation made;
- the inherent unlikelihood of the occurrence alleged;
- the gravity of the consequences flowing from an adverse finding; and
- if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

19. The effect of the authorities is that coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

FORENSIC INVESTIGATION

Identification

20. A Statement of Identification was completed by Paul's cousin, Pampana Sreekanth, at the Austin Hospital on 8 February 2014.

21. Paul's identity was not in dispute and required no further investigation.

Medical cause of death

Autopsy

22. On 11 February 2014 at the Victorian Institute of Forensic Medicine (VIFM), Dr Joanna Glengarry, Forensic Pathology Fellow under the supervision of Forensic Pathologist Dr Sarah Parsons, performed an autopsy on the body of Paul. Anatomical findings included:

    1. Near drowning episode
        a. Hypoxic ischaemic encephalopathy
        b. Predominantly eosinophilic myocarditis
        c. Bilateral pleural effusions; left 100ml, right 50ml
        d. Pleural oedema and congestion
        e. Aspiration pneumonia
    2. Left hilar lymph node necrosis
    3. Healing bruise to tip of tongue
    4. Healing abrasion to right elbow
    5. Mild right coronary artery atheroma

23. Dr Glengarry reported that there was no suitable ante mortem blood samples available from the hospital for toxicological analysis. She noted that the toxicological analysis of a post mortem sample was non-contributory to Paul's death.

24. Dr Glengarry reported that there was no post mortem evidence of violence or injury contributing to death and she stated that no clear reason was identified following a full post mortem examination as to why Paul developed difficulties in the water. Dr Glengarry ascribed the cause of Paul's death to hypoxic ischaemic encephalopathy in the setting of immersion.

Inquest brief

25. Detective Leading Senior Constable Emma Bennett from Banyule Criminal Investigation Unit was nominated to be the coroner's investigator[18] and she prepared the Inquest brief.

THE INQUEST

View

26. On 28 November 2014, I attended the premises of WaterMarc Leisure Centre in Greensborough for a view of the aquatic area and a demonstration of the boom being put in place to the middle of the 50 metre pool and returned to its seated position at the deep end of the pool. The process was recorded on my behalf by Victoria Police Forensic Services Department, Major Crime Scene Unit.

Direction Hearings

27. On 19 December 2014, I conducted a Directions Hearing. The interested parties present were:

- Banyule City Council represented by Ms C. Dunlop;
- Belgravia Leisure Pty Ltd represented by Mr Stephen Russell of Counsel;
- Leading Senior Constable (LSC) Stuart Hastings from the Police Coronial Support Unit (**PCSU**) was Counsel Assisting.

28. Counsel Assisting indicated that the areas identified in the course of the investigation that required exploration at an Inquest included:

- Did the movement of the boom contribute to Paul drowning;
- Was it appropriate to move the boom when patrons were still in the water;

[18] A coroner's investigator is a member of the police force nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions directly from a coroner and carries out the role subject to the direction of a coroner.

- What risk assessments were made prior to moving the boom;
- Did the process of moving the boom affect the supervision of the patrons by the lifeguards;
- Was supervision of the patrons adequate despite apparent compliance with industry ratios.

29. Mr Russell questioned whether the matter should be listed for Inquest because he understood that WorkSafe may still be intending to issue proceedings against his client under the *Occupational Health and Safety Act*. I informed Mr Russell that I had not received any communication from Worksafe.
30. I also indicated to the interested parties that having had the opportunity to view the process of the movement of the boom, it appeared to be a laborious procedure that necessitated the full concentration of at least two lifeguards. I noted that this needed to be considered in light of whether the ratio of lifeguard to patron was effectively maintained.
31. On 17 February 2015 I conducted a second Directions Hearing. The interested parties present were:
    - Banyule City Council represented by Mr D. McQualter of Maddocks Lawyers;
    - Belgravia Leisure Pty Ltd represented by Mr Stephen Russell of Counsel;
    - Victorian WorkCover Authority (**VWA**) represented by Mr A. Imrie of Counsel;
    - LSC Stuart Hastings from the PCSU was Counsel Assisting.
32. Mr Imrie indicated that the reason for the VWA's appearance was predominantly to inform me of how the Authority had been involved in investigating the incident thus far. He said that the VWA's involvement had been relatively minimal and that no issues had arisen. Mr Imrie stated that he did not have instructions about the VWA's continuation in the proceedings.
33. All interested parties agreed that no issues concerning the response and involvement of emergency services personnel had been identified. Therefore, none of the personnel involved in the attendance at the pool, resuscitation and transportation of Paul were required to give evidence at the Inquest. Similarly, no issues had been identified in respect of the medical management of Paul at the Austin Hospital or with the cause of death.
34. The witness list was for all intents and purposes, agreed upon.

Evidence at the Inquest

35. *Viva voce* evidence was obtained from the following witnesses at Inquest:

- Virajitha Kelangi
- Steven Ginn
- Natalie Ginn
- Jason Icovski
- Rebecca Festini
- Graeme Proctor
- Dr Daina Rumbergs
- Luke De Pasquale[19] – Duty Manager and Lifeguard
- Lina Khaldie
- Hugh Sheridan - Duty Manager, Lifeguard and Receptionist
- Walid Khaldie
- Andrew Burgess - Lifeguard
- Trent Ramsay - Duty Manager and Lifeguard
- Timothy Chong - Lifeguard
- Gary Cole[20] – Centre Manager
- Drew Hildebrand – Regional Manager
- Andrew Dennis – Commercial Service Manager, Life Saving Victoria

Notification of changes at WaterMarc

36. At the opening of the Inquest and prior to hearing from any of the witnesses, Mr Russell of Counsel, on behalf of Belgravia Leisure Pty Ltd, informed the Court that subsequent to the drowning incident and my attendance at WaterMarc for a view on 28 November 2014, there had

[19] A successful application was made pursuant to section 57 of the *Coroners Act 2008* for Mr Luke De Pasquale to be granted a certificate pursuant to section 57(1)(b) of the Act. The certificate enables the witness to give evidence at the Inquest without that evidence being used in any proceeding against him. T @ pp 101-103.

[20] A successful application was made pursuant to section 57 of the *Coroners Act 2008* for Mr Gary Cole to be granted a certificate pursuant to section 57(1)(b) of the Act. The certificate enables the witness to give evidence at the Inquest without that evidence being used in any proceeding against him.

been a reassessment of the procedures surrounding the movement of the boom. Mr Russell indicated that after the Directions Hearing on 17 February 2015 there were:

> *..discussions between himself and others involved in the operation of the centre it was thought certainly appropriate to make sure that the area was clearly identified and that a no go zone is marked in that short area between the shallow and the deep end of the pool.*[21]

37. In particular, Mr Russell stated that as soon as the boom *"moves away from the location separating the two pool areas a lifeguard is designated to the drop off zone to stand there at the time."* In addition, Mr Russell informed me that further attention is drawn to the drop off zone after the removal of and positioning of the boom by the placement of an extra set of tubing or barriers *around that drop off zone that connects to the pool ropes or lane dividers so that it is marked clearly as an area that no one is entitled or permitted to go into.*[22]

WaterMarc Aquatic and Leisure Centre

38. WaterMarc is owned by Banyule City Council and managed by Belgravia Leisure Pty Ltd. WaterMarc opened in September 2012 and is a multi-activity facility comprising an aquatic centre and gymnasium. The aquatic centre is comprised of 3 pools, 2 waterslides and an aquatic adventure playground, all situated on the ground floor of the facility. WaterMarc is open Monday to Friday from 6.00am to 10.00 pm and on the weekends and public holidays between 7.00 am and 8.00 pm.

39. On 2 February 2014 at 1.30 pm, Mr Luke Pasquale commenced work at WaterMarc as the Duty Manager (**Duty Manager De Pasquale**) for the remainder of the operating hours. He had worked at WaterMarc for 14 months and stated that when he started his shift that day *the centre was obscenely busy and it was probably up there with the busiest day I have had since working the summer.*[23]

The 50 metre pool[24]

40. The 50 metre pool[25] is the largest pool at WaterMarc and is 18 metres wide with varying depths. The northern or shallow end of the pool is 1.35 metres in depth and the southern or deep end of the pool is 2.1 metres in depth. From the northern/shallow end to the middle of the pool there is

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[21] T @ p 7.

[22] T @ p 6.

[23] Exhibit 10 – Statement of Luke De Pasquale dated 27 February 2014.

[24] The 50 metre pool is also referred to as **"the lap pool"** by a number of witnesses.

[25] The actual measurement length of the 50 metre pool is apparently 51.5 metres.

a gradual decline from the 1.35 metres to 1.4 metres and from here there is a drop off point to 2.1 metres with the drop off being approximately 1.5 metres wide.

41. The 50 metre pool can be divided to create two separate pools by the placement of a moveable boom or floating deck (**the boom**). The boom is 1.5 metres wide with a depth of 1.2 metres and has a skirt like attachment which sits on the floor of the pool and prevents patrons from swimming underneath the boom. When the boom is retracted to the 50 metre position, a 1.2 metre wide "drop off" zone is created at a water depth of 1.4 metres and represents an area where the pool depth changes rapidly.[26] When the boom is in position to create the two pools, the drop off zone is not apparent because the boom covers the entire slope.[27] A patron at the boom as it is retracted would experience a sudden[28] change in the depth. Signage on both sides of the pool alert patrons to the drop off zone and the space is depicted by red lines on the bottom of the pool both at the start of the drop off and where the drop off finishes.[29] The signage which is co-located within the "1.4m" sign[30] provides a visual warning of the change in depth at the location and was installed at the recommendation of Life Saving Victoria. According to the Critical Incident Systems Review[31] conducted by Life Saving Victoria, after Paul's death the signs *were (and are) believed to be compliant with the relevant signage standard and GSPO provisions.*[32]

Swimming experience of Paul and Ms Kelangi

42. Paul had limited swimming experience[33] and Ms Kelangi could not swim.[34] On entering WaterMarc they did not inform anyone of their lack of ability in the water and proceeded to enter the 50 metre pool. There is no signage or any other prompt for poor and/or non-swimmers to alert lifeguards about their lack of swimming capacity.[35]

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[26] T @ p 116.

[27] T @ p 262.

[28] T @ p 258, 271.

[29] T @ p 116.

[30] Inquest Brief (Exhibit 34) @ p 168.

[31] Inquest Brief (Exhibit 34) @ p 153.

[32] Inquest Brief (Exhibit 34) @ p 168.

[33] T @ p 10.

[34] Exhibit 1 – Statement of Virajitha Kelangi dated 17 February 2014, T @ p 9.

[35] T @ p 15.

43. Ms Kelangi did however acknowledge that she had seen the signage depicting the depths of the shallow and deep ends of the pool.[36]

Conditions at WaterMarc on 2 February 2014

44. According to Duty Manager De Pasquale the number of patrons in the water was approximately 700 at the peak time of the day, mid-afternoon at between 3.00 – 4.00 pm[37] and this did not include the patrons in the surrounding areas around the water,[38] also referred to as the pool deck.

45. Lifeguard Andrew Burgess (**Lifeguard Burgess**) worked two shifts on 2 February 2014. He was rostered for the shift between 10.00 am and 2.00 pm and returned to WaterMarc for the 4.15 pm – 8.00 pm shift after he saw a request for additional staff on Facebook, once he had returned home. When he got back to the pool at 4.15 pm, he said that it was not as busy as it had been earlier in the day and estimated that there were between 500 and 1000 patrons in the aquatic centre.[39]

46. Lifeguard Trent Ramsay (**Lifeguard Ramsay**) had also worked that morning between 10.00 am and 1.30 pm as the Duty Manager, and then returned to work the shift from 5.00 pm until 8.00 pm. He described the day as hot and that it was *ridiculously busy* and estimated that there *were in excess of 500 people at the centre* at the start of his shift.[40]

47. The waterslides/splash park had been closed at approximately 6.00 pm but there were three pools operating at the time Paul and Ms Kelangi arrived at WaterMarc – the leisure pool, the warm water program pool/hydro pool and the 50 metre pool.

48. Ms Kelangi recalled that the conditions when she and Paul were entering the 50 metre pool were crowded, and there were a lot of people there;[41] *there were a lot of people in the pool.*[42]

49. Mrs Lina Khaldie (**Mrs Khaldie**) and husband Walid Khaldie (**Mr Khaldie**) and their eight children arrived at WaterMarc sometime between 3.00 and 4.00 pm. The boom was in position in the middle of the 50 metre pool.

50. Mr Steven Ginn (**Mr Ginn**) arrived at WaterMarc at approximately 6.30 pm with his wife Natalie (**Mrs Ginn**) and their two children. Mr Ginn stated that it was a very hot day, *like a 40-*

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[36] T @ p 9.

[37] Exhibit 10 – Statement of Luke De Pasquale dated 27 February 2014.

[38] Exhibit 10 – Statement of Luke De Pasquale dated 27 February 2014, as amended – T @ p 105.

[39] Exhibit 18 – Statement of Andrew Burgess dated 7 April 2014, T @ p 241.

[40] Exhibit 21 - Statement of Trent Ramsay dated 26 February 2014.

[41] Exhibit 1 – Statement of Virajitha Kelangi dated 17 February 2014.

[42] T @ p 12.

plus day so it was quite busy.[43] He said that there were a lot of people in the water and *heaps of jumping going on.*[44] He stated that this was occurring at the far end or deep end of the pool where *heaps of people* were jumping and carrying on.[45] Mrs Ginn described this behaviour as *bombing into the water* and *thought it was just too dangerous.*[46] Mr Ginn and his family initially entered the 50 metre pool but around the time the lane partition ropes were being removed by lifeguards, the Ginn family decided to move to the leisure pool.[47] The boom was still in place at that time.[48]

51. Mr Graeme Proctor (**Mr Proctor**) arrived at WaterMarc at approximately 6.25 pm. He had been to the complex on a Sunday on two previous occasions and stated that *there were a lot more people than the previous Sundays.*[49] When he arrived the boom was in place, as were the lane dividers and this was the same as the previous Sundays. He estimated that by 7.10 pm the lane dividers had all been removed and at approximately 7.15 pm the boom started to be returned to the deep end of the pool. He said that the boom had reached the deep end of the pool by about 7.25 pm. Mr Proctor stated that this had not occurred during his previous attendances, when the boom had not been removed while swimmers were in the pool,[50] and he was surprised that they were going to move it *with so many people in the pool and it was only half an hour before closing time.*[51]

52. Dr Daina Rumbergs (**Dr Rumbergs**) arrived at WaterMarc at approximately 6.45pm. She said that there were a lot of people which made her feel unsure if she wanted to swim. She said that the place felt congested.[52] The main pool was still divided by the boom and there were some lap dividers in place. After approximately 10 minutes in the water, Dr Rumbergs noticed that two lifeguards were starting to remove the lane dividers. Shortly thereafter, whilst attempting to swim laps, Dr Rumbergs got *nearly bombed on* by a patron that was jumping into the water from the pool's edge. The incident made her feel *very unsafe* and shaken.[53] She looked for a

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[43] T @ p 27.

[44] Exhibit 2 – Statement of Steven Ginn dated 18 February 2014.

[45] T @ p 17, 21, 31.

[46] Exhibit 3 – Statement of Natalie Ginn dated 12 February 2014.

[47] Exhibit 2 – Statement of Steven Ginn dated 18 February 2014.

[48] T @ p 22.

[49] Exhibit 7 – Statement of Graeme Proctor dated 11 February 2014, T @ p 78.

[50] Exhibit 7 – Statement of Graeme Proctor dated 11 February 2014, T @ p 79, 81, 82.

[51] T @ p 85.

[52] Exhibit 8 – Statement of Daina Rumbergs dated 2 March 2014.

[53] Exhibit 8 – Statement of Daina Rumbergs dated 2 March 2014.

lifeguard to report the incident to but there were none close to her. Dr Rumbergs got out of the water and approached a lifeguard on the north side[54] of the pool, who was at the boom in the middle of the pool, to enquire if the lane dividers were going to be replaced. She was informed that they would be replaced after the boom had been returned to the far/deep end of the pool. After waiting for five to 10 minutes, Dr Rumbergs decided to return to the water, swimming from the shallow end to the boom on approximately four occasions. At 7.25 pm she decided to leave, stating that *it just felt chaotic and unsafe.*[55]

53. Jason Icovski (**Mr Icovski**) and his girlfriend, Rebecca Festini (**Ms Festini**) arrived at WaterMarc sometime before 7.00pm.[56] Mr Icovski *instantly thought it was way too packed. There were people and bags everywhere.*[57] Ms Festini also thought there were too many people, never having seen that many people at WaterMarc in her previous visits to the pool.[58] She also stated that there were a *lot of kids jumping.*[59] When the couple entered the pool, the boom had already been moved from the drop off zone.[60] Mr Icovski and Ms Festini recalled seeing Ms Kelangi and Paul splashing around *in the shallow end just before the drop off about two metres from the wall on the south side.*[61] The couple also saw Paul and Ms Kelangi jumping up and down and putting their heads under the water.[62] Ms Festini was keen to move away from Paul and Ms Kelangi as she was getting splashed in the face and was concerned for her own safety, as she is not a strong swimmer. She was not concerned for them; she did not believe they were drowning.[63]

54. At the time of the drowning, Duty Manager De Pasquale estimated there were approximately 300 patrons remaining in the aquatic area of WaterMarc approximately 50 of which were in the

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[54] The north side of the pool was identified by Dr Rumbergs as being where the seating is. – T @ p 88.

[55] Exhibit 8 – Statement of Daina Rumbergs dated 2 March 2014.

[56] T @ pp 61-62. Ms Festini stated that they arrived at *some time after 7.15pm* - Exhibit 6 – Statement of Rebecca Festini – dated 11 February 2014. In her *viva voce* evidence she agreed that 7.15pm could have been when they entered the water.

[57] Exhibit 5 – Statement of Jason Icovski dated18 February 2014.

[58] Exhibit 6 – Statement of Rebecca Festini – dated 11 February 2014, T @ p 71. Ms Festini estimated that she had been at WaterMarc approximately 10 times before 2 February 2014.

[59] T @ p 69.

[60] T @ p 57.

[61] Exhibit 5 – Statement of Jason Icovski dated18 February 2014, T @ p 58.

[62] T @ p 60.

[63] Exhibit 6 – Statement of Rebecca Festini – dated 11 February 2014, T @ pp 73 - 74.

50 metre pool.[64] Lifeguard Burgess estimated that approximately 500 patrons remained in the aquatic area at the time of the drowning.[65]

Lifeguard/patron ratio

55. The Guidelines for Safe Pool Operations (**GSPO**) developed by the Royal Life Saving Society Australia, recommend that the minimum number of lifeguards required to be directly engaged in lifeguard activities is 1:100 patrons. The ratio applies to patrons in the water.[66]

56. At or around the time Paul and Ms Kelangi entered the pool at WaterMarc, there were seven qualified lifeguards[67] on duty. At or around the time of the drowning of Paul and Ms Kelangi there were six[68] lifeguards on duty which *prima facie* exceeds the recommended ratio, based on the estimate of 300 patrons. The Duty Manager does not comprise one of the lifeguards in the formulation of the ratio.[69] Lifeguard Hugh Sheridan (**Lifeguard Sheridan**) was working on the reception desk from 1.00 pm to 6.00 pm but had stayed on at the end of his shift to work as a lifeguard at the request of Duty Manger De Pasquale, due to the large number of patrons on that day. Lifeguard Sheridan initially relieved one of the other lifeguards for a break. He was then effectively removed from the lifeguard to patron ratio by Duty Manager De Pasquale, who delegated some of his own administrative duties to Lifeguard Sheridan.[70]

57. The estimate of 300 patrons necessitates the stationing of at least one lifeguard at each of the three pools operating at the time. The contentious issue is whether all of these lifeguards were available or capable of effectively supervising the patrons at the relevant time, and whether a lifeguard was dedicated to the 50 metre pool such that effective supervision of the patrons was occurring at or around the relevant time. In his *viva voce* evidence Duty Manager De Pasquale said that the lifeguards designated to move the lane dividing ropes are not included into the ratio, nor are the lifeguards moving the boom, or the lifeguard sent to the treatment room to do the water testing.[71]

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[64] T @ p 107, 173.

[65] Exhibit 18 – Statement of Andrew Burgess dated 7 April 2014.

[66] Exhibit 32 – Statement of Andrew Dennis dated 8 April 2014.

[67] The average age of the lifeguards on duty was 18.7 years. Duty Manager De Pasquale was the eldest staff member being 25 years of age at the time.

[68] At or around 7.30 pm Lifeguard Jayde Van Hoff had finished her duties and was about to leave the pool. She was approaching Duty Manager De Pasquale and Lifeguard Sheridan at the deep end of the 50 metre when they became aware of a crowd seeking their attention – Inquest Brief @ p 75.

[69] T @ p 163.

[70] T @ pp 211 – 213, 339, 340.

[71] T @ p 172.

58. Duty Manager De Pasquale sought the assistance of Lifeguard Timothy Chong (**Lifeguard Chong**) to help with moving the boom, which effectively removed a lifeguard from those available to supervise the patrons. At the same time, Lifeguard Ramsay held the 50 metre pool radio and was standing down at the shallow end of the 50 metre pool. At this time there were two lifeguards; Lifeguard Mitchell Larder (**Lifeguard Larder**) and Lifeguard Burgess were supervising the patrons at the leisure pool which is the second largest pool and contains several water features for interactive use.

Decision to move the boom

59. The GSPO does not prohibit movement of the boom during operational hours and Mr Drew Hildebrand, Regional Manager said that the boom can be moved *within operational hours when it is safe to do so provided the duty manager is ensuring that there's enough people to scan and watch the pool.*[72]

60. Duty Manager De Pasquale had been involved in moving the boom in excess of 80 times without incident.[73] On 2 February 2014, Duty Manager De Pasquale decided to move the boom back to the 50 metre position at the deep end of the pool prior to closing time, 8.00 pm. He stated that:

> *Normally we would start moving the boom in the 50 metre pool at around 7.30 pm but because of how busy it was everything got pushed forward a little bit.*[74]

61. Duty Manager De Pasquale said that from around 7.00 pm they start making preparations for the next day by cleaning up, moving patrons, and things that facilitate closing the pool on time. He said that this was particularly so in the summer months as the lifeguards work as long as eight hours and that lifeguarding is *quite dry and boring and a bit mind numbing doing that for eight hours.*[75]

62. In his statement, Duty Manager De Pasquale acknowledged that moving the boom is *a long process for the average guy because it is physical labour and you have to be organised and have time management which some people don't have.*[76] Before commencing the process on 2 February 2014, Duty Manager De Pasquale stated that he made an assessment that it was safe to

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[72] T @ p 373.

[73] T @ p 136.

[74] Exhibit 10 – Statement of Luke De Pasquale dated 27 February 2014, T @ p 120.

[75] T @ p 165.

[76] Exhibit 10 – Statement of Luke De Pasquale dated 27 February 2014.

move the boom[77] based on the number of patrons remaining in the 50 metre pool. Although Duty Manager De Pasquale initially stated that he did not estimate the number of patrons remaining in the 50 metre pool before the commencement of the process,[78] he later said that when he was returning to the 50 metre pool from attempting to make the public announcement about closing time, he estimated the number of patrons remaining in the 50 metre pool to be approximately 50.[79]

63. In his *viva* voce evidence, Duty Manager De Pasquale said that the boom may be moved if there is a program scheduled or at closing at about 7.30pm, but it is the duty manager's discretion when to move the boom *if the pool is not busy or there is no one in there we are able to move it as long as we are informing the patrons and ensuring that everyone is safe within the water.*[80]

64. On 2 February 2014, Duty Manager De Pasquale was however unable to make a public announcement prior to the commencement of removing the boom, as the speakers or the public announcement system was not working[81] or had only been working intermittently.[82]

65. At the time Duty Manager De Pasquale made his assessment that it was safe to move the boom, he did not take into account that the process may be prolonged necessitating additional time and resources if the boom did not sheet home immediately.[83]

Supervision of the 50 metre pool while the boom was being moved

66. According to the Centre Manager at the time, Mr Gary Cole (**Mr Cole**), moving the boom is not inherently dangerous as long as *the staff are there to move the lane ropes first, and then the boom, while someone is supervising the pool.*[84]

67. The operation of moving the boom requires a minimum of two people and takes approximately 30 minutes to complete. As witnessed at the view I attended at WaterMarc, it is a very labour intensive process. Before the boom can be moved, lifeguards detach all lane dividing ropes attached to the boom and wind these ropes onto large portable reels. To move the boom large steering wheels are attached to each side of the boom and red guides are attached at the base which assist in keeping the boom aligned from both sides of the pool. Lifeguards manually turn

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[77] T @ pp 136 – 137, 138.

[78] T @ pp 119 – 120.

[79] T @ p 173.

[80] T @ p 117.

[81] T @ p 121.

[82] T @ p 149, 158.

[83] T @ p 138.

[84] T @ p 326.

the steering wheels to either move the boom to the middle of the pool or return the boom to the deep/southern end of the pool, as was the case on the evening of 2 February 2014.

68. Once the boom reaches its end point, it must be aligned so it can be seated into position. The steering wheels are also removed so as to prevent movement and interference by patrons. If the boom is out of alignment it cannot be seated into position and secured. When such a situation occurs, the boom needs to be refloated[85] to enable alignment and completion of the process of seating or parking the boom so that it is rendered safe.

69. Duty Manager De Pasquale sought the assistance of Lifeguard Chong[86] who had just returned from a break, and Lifeguard Ramsay was given the task of supervising the 50 metre pool while the process was being undertaken.[87]

70. According to Lifeguard Chong there were still some people in the deep end of the pool[88] while the boom was being retracted but according to Duty Manager De Pasquale, the deep end of the pool was cleared before the process began and the boom was moved back to the deep end without incident. There was a delay to completing the process however because the boom could not be "sheeted home" and consequently needed to be refloated. According to Duty Manager De Pasquale, the job of refloating the boom is usually only done by a Duty Manager.[89]

71. The lifeguards involved directed their attention towards completing the process of sheeting home the boom in order to render it stable and safe. At around this time, approximately 7.20pm, Lifeguard Sheridan came down from the upstairs area where he had been performing administrative duties. He recalled that at this time the boom was a few metres away from the end of the pool.[90] After a discussion with Duty Manager De Pasquale, Lifeguard Sheridan decided to help with the refloating of the boom and directed Lifeguard Ramsay to carry out the pool tests which necessitated Lifeguard Ramsay leaving the pool deck area and going to the basement of the building.[91] At that time, Lifeguard Ramsay estimated that there were approximately 80 patrons remaining in the 50 metre pool.[92]

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[85] Duty Manager De Pasquale explained that a pump is used to fill the ballast tank under the boom with air so that the boom floats back up and allows for it to be manually repositioned. – T @ p 121.

[86] T @ p 138.

[87] T @ pp 138 – 139.

[88] Exhibit 23 – Statement of Timothy Chong dated 8 April 2014.

[89] T @ p 151.

[90] T @ p 204.

[91] T @ p 261.

[92] T @ p 259.

72. Duty Manger De Pasquale stated that once Lifeguard Ramsay left the pool area, Lifeguard Chong became responsible for the lifeguard duties at the 50 metre pool.[93] He said that even if he did not explicitly tell Lifeguard Chong to take up the role of supervising the 50 metre pool, he was the lifeguard with the 50 metre pool radio which meant that Lifeguard Chong *was required to default back to watching the pool.*[94]

73. Lifeguard Chong on the other hand said that he did not believe that he had been tasked with supervising the 50 metre pool and could not remember having been given the radio for the 50 metre pool.[95] Lifeguard Chong said that during a rotation of the lifeguards around the aquatic area, the radio for the 50 metre pool would be handed over to the lifeguard coming into duties for that pool and that a flotation device called a rescue tube may also be handed over for that lifeguard to carry.[96]

74. Lifeguard Ramsay stated that he in fact had the 50 metre pool radio and that he forgot to hand it over when he was directed to attend to the water testing in the basement. When he realised that he was still in possession of the 50 metre pool radio, he decided not to return to the pool area to hand it over as he was aware that both Duty Manager De Pasquale and Lifeguard Sheridan were in possession of radios.[97]

75. At approximately 7.20 pm, Duty Manager De Pasquale left Lifeguards Chong and Sheridan at the deep end of the 50 metre pool with the unseated boom to go to the reception to make an announcement that the pool would be closing at 8.00 pm. He was not however able to make an announcement as the public announcement system was still not working. He returned to the 50 metre pool where Lifeguard Sheridan was tending to power cords needed for the purposes of refloating the boom and Lifeguard Chong was likewise engaged. Duty Manager De Pasquale set about assisting the two lifeguards with this task.

Implementation of resuscitation

76. At some time after the boom had been removed from the middle of the pool, Mr Khaldie noticed Ms Kelangi floating face down in the 50 metre pool. He commented to his sister and/or Mrs

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[93] T @ p 122.

[94] T @ p 153.

[95] T @ p 287.

[96] T @ pp 287 – 288.

[97] T @ p 267. Lifeguard Sheridan had possession of the "operations radio" which is usually held by management staff during the week – T @ p 205.

Khaldie that he could not comprehend how she was holding her breath for so long. Mr Khaldie asked one of his children to touch her and when she did not move in response, Mr Khaldie lent into the pool from the pool deck and grabbed Ms Kelangi by the arm out of the water and onto the pool deck.[98] Mrs Khaldie said she started screaming and waving in an attempt to get the attention of the lifeguards who were standing in the *north west corner of the big pool.*[99]

77. Mr Ginn and his family were returning to the 50 metre pool from the leisure pool when they came across an unconscious Ms Kelangi lying on her back on the concrete surrounded by a large group of people *milling around and waving their hands towards lifeguards* at the leisure pool. Mr Ginn called out "life guard", got the attention of one and called "life guard" again reinforcing that assistance was needed.[100]

78. At approximately 7.30pm, Lifeguard Larder who was situated at the leisure pool, became aware that a group of patrons gathered at the midpoint of the 50 metre pool were making attempts to attract the attention of the lifeguards. Lifeguard Larder moved quickly to where the patrons were gathered and located an unconscious Ms Kelangi. The patrons informed Lifeguard Larder that they had pulled her from the water after she had been located face down. Soon after, Lifeguard Burgess also came over from the leisure pool to the commotion and assisted Lifeguard Larder who had commenced CPR on Ms Kelangi.

79. While Lifeguards Larder and Burgess were making their way over to Ms Kelangi, Mr Ginn's attention was drawn to the pool by another patron who exclaimed that there was another person at the bottom of the pool. Mr Ginn looked over the edge of the pool and saw Paul face up on the bottom of the pool in the deep end. He was in the first lane, very close to the edge of the pool, estimated by Mr Ginn to be *about one and a half metres west of where the partition is normally in place.*[101] Mr Ginn dived into the pool and retrieved Paul from the bottom, bringing him to the surface. As Mr Ginn surfaced with Paul, Lifeguard Larder jumped into the water behind him.[102] Mr Ginn called for assistance and two male patrons took hold of Paul and pulled him from the

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[98] Exhibit 16 – Statement of Walid Khaldie dated 22 February 2014.

[99] Exhibit 13 – Statement of Lina Khaldie dated 22 February 2014.

[100] Exhibit 2 – Statement of Steven Ginn dated 18 February 2014, Exhibit 3 - Statement of Natalie Ginn dated 12 February 2014.

[101] Exhibit 2 – Statement of Steven Ginn dated 18 February 2014, T @ p 23.

[102] T @ p 39.

water.[103] By the time Mr Ginn removed himself from the water, a lifeguard was attempting to render assistance to Paul. Mr and Mrs Ginn both provided some advice and assistance to the lifeguard[104] but Mr Ginn emphasised that the lifeguard *was fine, he was good, he just went straight to it and was calm.*[105] CPR was commenced with the lifeguard performing chest compressions and Mrs Ginn was assisting. When a female patron identified herself as a doctor, Mrs Ginn stood aside. Dr Rumbergs had seen the commotion when she was at her locker and had asked a staff member (Hugh Sheridan), who had retrieved equipment from the First Aid Room, if he required any help. She had identified herself as a doctor at that stage. Dr Rumbergs followed Lifeguard Sheridan to the south side of the pool and immediately rendered assistance with Paul, focussing on getting his airways open as the lifeguard continued with compressions. Dr Rumbergs noted there was a lot of froth coming out of Paul's mouth and nose. He was not breathing spontaneously. His pupils were fixed and dilated and Dr Rumbergs could not locate a pulse. She thought that Paul had died. She was provided with an oxygen mask to assist with her attempts at artificial respirations but felt thwarted by the amount of froth/foam emanating from Paul's airways. In her *viva* voce evidence, Dr Rumbergs said that she thought the lifeguards were all doing the right things.[106]

80. After standing aside to enable Dr Rumbergs to render assistance, Mrs Ginn was subsequently directed by a staff member to go to the Reception to retrieve extra emergency oxygen. Mrs Ginn was provided with two bags from the Reception staff, one of which was a defibrillator. When a defibrillator was made available it became apparent that Pauls's feet were still in the water. Mr Ginn and the lifeguard lifted him under the armpits to remove him completely from the water but in the process of laying him back on the concrete surface, Paul's head hit it heavily.[107] At some stage the defibrillator pads were placed on Paul's chest by Lifeguard Sheridan but when

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[103] T @ p 19. Mrs Khaldie believed it was her sister-in-law's husband, Mohammed Mina and a lifeguard that pulled Paul from the water – Exhibit 13 – Statement of Lina Khaldie dated 22 February 2014, T @ p 177.

[104] Exhibit 3 - Statement of Natalie Ginn dated 12 February 2014.

[105] T @ p 19, 29. Mrs Ginn also said that once the staff got there – *they were great, you couldn't fault them.* – T @ p 47.

[106] T @ p 90.

[107] Exhibit 2 – Statement of Steven Ginn dated 18 February 2014. Mrs Ginn stated that Paul's head hitting the concrete occurred when Paul was removed from the water in the first instance – Exhibit 3 - Statement of Natalie Ginn dated 12 February 2014. Mrs Khaldie also stated that this occurred when Paul was removed from the water in the first instance - Exhibit 13 – Statement of Lina Khaldie dated 22 February 2014.

he pushed the button to commence the process the machine advised "no shock advised".[108]

81. Duty Manager De Pasquale was not physically involved in the resuscitation endeavours of Paul and Ms Kelangi but maintained a supervisory role,[109] as well as attending to removing the bollards near the front door of the complex, enabling emergency vehicles closer access to the entrance.

82. Members of the Fire Brigade were first responders, followed shortly thereafter by Mobile Intensive Care Ambulance (MICA) paramedics. Dr Rumbergs stood aside to enable emergency services personnel to manage Paul and Ms Kelangi.[110]

Patrons' perception of the overall supervision and control of the aquatic centre on 2 February 2014

83. Evidence of the patrons consistently depicted a sense of a lack of supervision, including a lack of control of rowdy patrons in a very crowded pool.[111] Mrs Ginn stated *not once did I see the guards pull anyone up.*[112] Mr Icovski stated that he felt *like the place was understaffed that day, I only saw three life guards.*[113] Ms Festini said that she remembered that she *thought there too many people in the lap pool.*[114] Dr Rumbergs was quite shaken by the man nearly jumping on her and at that point *felt there wasn't anyone around reprimanding him.....no one pulled him up.*[115] Mrs Khaldie stated that she thought the events of the day occurred because of a *lack of staff.*[116] Mr Khaldie thought moving the boom could have caused some confusion for the swimmers, that the lifeguards were young but should be older with more experience, and *if they were around the swimming pool as well maybe they could have saved them but they were*

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[108][108] Exhibit 14 – Statement of Hugh Sheridan dated 17 March 2014.

[109] T @ p 145.

[110] Lifeguard Burgess had continued with the CPR on Ms Kelangi after Lifeguard Larder went to assist with Paul. When Ms Kelangi recommenced spontaneous breathing, Lifeguard Burgess was assisted by Mr Khaldie to place her in the recovery position – T @ pp 248-249.

[111] Exhibit 3 - Statement of Natalie Ginn dated 12 February 2014, Exhibit 4 - email from Natalie Ginn to Gary Cole dated 5 February 2014, T @ pp 34-35.

[112] T @ p 37.

[113] Exhibit 5 – Statement of Jason Icovski dated18 February 2014, T @ p 59.

[114] Exhibit 6 – Statement of Rebecca Festini – dated 11 February 2014.

[115] T @ p 93.

[116] T @ p 179.

chatting in the corner.[117]

Response to rowdy behaviour

84. At 6.50pm Duty Manager De Pasquale had telephoned Police seeking their attendance and assistance with two teenage males doing backflips into the pool, endangering others in the pool and refusing to leave the complex. At 7.02pm the request for assistance was cancelled by Duty Manager De Pasquale as the people of concern had left the complex.[118]

Additional changes at WaterMarc

85. Notification at the outset of the Inquest of the changes associated with the movement of the boom did not include that there had been a directive of any kind through Belgravia Leisure Pty Ltd that the boom was not to be moved during the busy periods. Duty Manager De Pasquale on the other hand stated in his *viva voce* evidence that as far as he understood *the boom will now be locked during the busy periods, it won't be moved at all, period.*[119] Lifeguard Burgess in his *viva voce* evidence said that since this incident we no longer move the boom whilst patrons are *in the water and we put pool noodles around the drop off zone in the aqua play section so that patrons are made more aware that there is a hazard there.*[120]

86. Mr Cole was the Centre Manager of WaterMarc at the time of the drowning of Paul and at the time of making his original statement.[121] He became the Regional Manager for Belgravia Leisure for Victoria and Tasmania in December 2014. Mr Cole provided a supplementary statement[122] during the running of the Inquest on 21 May 2015, outlining the implementation of changes that had occurred at WaterMarc, including those that had arisen from the completion of the Critical Incident Systems Review Report[123] by Life Saving Victoria (**LSV**) dated 24 February 2014. In his supplementary statement, Mr Cole noted that the administrative changes made in relation to the movement of the boom were included in Safe Work Method Statement (**SWMS**) 123 as follows:

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[117] Exhibit 16 – Statement of Walid Khaldie dated 22 February 2014.

[118] Inquest Brief @ pp 214-215.

[119] T @ p 130.

[120] T @ p 246.

[121] Exhibit 27 – Statement of Gary Cole dated3 September 2014.

[122] Exhibit 28 – Supplementary statement of Gary Cole dated 21 May 2015.

[123] Exhibit 34 – Inquest Brief @ p 153.

a) *That the Boom is to be moved only when safe to do so and consideration should be given by the Duty Manager to move it outside of operating hours.*

b) *The Duty Manager is to delegate a lifeguard(s) to constantly supervise the pool. This person is responsible to watch the water and will not be involved in moving the Boom.*[124]

87. WaterMarc's implementation of recommendations made by LSV included WaterMarc Area audits, updating guidelines for boom operation (SWMS 123), lifeguard supervision (SWMS 126), lifeguard rotations (SWMS 127), installation of additional signage at the drop off zone, development of a monthly in-service training plan for lifeguards and duty managers and review of incident report completion for the purposes of training by Area Managers. WaterMarc had added an additional lifeguard to the rosters to act as a "Runner" to assist the Duty Manager and an Operations Manager or Coordinator are rostered to work on weekends from December to March to support pool staff.[125]

88. In responding to further questions about any other changes that had occurred at WaterMarc since the death of Paul, Duty Manager De Pasquale said that a system for counting the number of patrons coming in and leaving the aquatic centre had been introduced with the effect that the Reception area staff are able to advise the Duty Manager if the numbers are such that the pool doors need to be closed.[126] Later in his evidence he said that such a system was in place at the time of the drowning of Paul and Ms Kelangi, where a staff member at reception used a clicker to count patrons coming and going from the pool and that similarly *if they got above capacity they would let him (sic) know and then he would (sic) be able to close the pool deck or assign more lifeguards.*[127] In addition, Duty Manager De Pasquale stated that in response to the difficulties that had been experienced with the public announcement system not working, including on 2 February 2014, *that there has been a loudhailer put on the pool deck in case we need to make an announcement and the speakers are not working.*[128]

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[124] Exhibit 28 – Supplementary statement of Gary Cole dated 21 May 2015.

[125] In his *viva voce* evidence Mr Cole stated that Gayle Demetriadis, Aquatic Operations Manager at been on duty at WaterMarc between the hours of 8.00 am to 6.30 pm or 6.45 pm – T @ p 341. James Owen also a Duty Manager and operations coordinator had also been present but had also left the premises before the movement of the boom and the critical incidents – T @ p 342.

[126] T @ p 131.

[127] T @ 162.

[128] T @ p 158.

89. Duty Manager De Pasquale's evidence about these additional changes became somewhat confusing, particularly in relation to the system about counting patrons. Belgravia Leisure Pty Ltd did not inform me of these additional changes and nor did they seek to clarify, substantiate and/or indeed correct this part of the evidence of their employee. I am therefore constrained in attaching anything but little weight to these aspects of Duty Manger De Pasquale's evidence. It is neither clear nor cogent.

Other matters

90. Mr and Mrs Khaldie both gave evidence that they were able to move in and out of the wet or pool area by a rear door situated at the deep end of the 50 metre pool, that was left open for extended periods without any supervision. The Khaldies raised this issue in the context of questions over whether the patrons were being adequately supervised by lifeguards on that day. Access and egress through this rear door was not conceded by WaterMarc but nevertheless I accept the submission made on behalf of Belgravia Leisure that I do not need to determine the accuracy or veracity of this evidence.

Closing submissions of Counsel Assisting

91. Counsel assisting submitted at the conclusion of the evidence that although WaterMarc had complied with the recommended ratio of one lifeguard per 100 patrons, the ratio was intended to be in reference to the availability of lifeguards to supervise patrons and not include those being involved in other duties.[129]

92. Counsel Assisting submitted at the conclusion of the evidence that it was open to me on the evidence that the decision to move the boom while patrons were still in the water was inappropriate for the conditions on the day.

93. Counsel Assisting submitted that there was compelling evidence that no one was supervising the 50 metre pool at the time of the drowning of Paul and Ms Kelangi because the lifeguards at the 50 metre pool were distracted due to the difficulty they were experiencing in aligning the boom at the far end of the pool.

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[129] Transcript of proceedings for 17 July 2015 @ p 3, T @ p 113.

APOLOGY[130]

94. Prior to the Inquest, none of the witnesses[131] that were WaterMarc patrons on 2 February 2014 had received any acknowledgement or thanks from Belgravia Leisure Pty Ltd for their efforts on the day.

95. In his written outline of closing submissions, Mr Russell of Counsel on behalf of Belgravia Leisure Pty Ltd stated:

> *Belgravia sincerely regrets the death of Mr Rayudu and extends its sympathy to the family of Mr Rayudu and to Virajithi Kelangi (Ms Kelangi). To the extent that it can, Belgravia has attempted to contact all the patrons that assisted in the rescue attempts and passed its thanks for the efforts made.*[132]

96. On 17 July 2015, the day set down for closing submissions, Mr Nick Cox, Chief Executive Officer of Belgravia Leisure Pty Ltd made a public expression of sympathy when he said he wanted to:

> *...personally express my sadness and regret and pass along our condolences to Ms Kelangi and the family and friends of Mr Rayudu...* [133]

COMMENTS

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

1. Paul and Ms Kelangi did not attend WaterMarc with the intention of entering the 50 metre pool, they had intended on using the waterslide. In those circumstances it is understandable that Paul's limited swimming experience and Ms Kelangi's inability to swim were not forefront in their minds when their plans were changed by the fact the waterslide was already closed. It is similarly understandable that they decided to remain at WaterMarc and enter the water - it was a hot day, they had come prepared for entering water, there were lots of other people in the water – it would have presented as an inviting situation. There was nothing to prompt them to inform staff / lifeguards of their lack of experience. If intuition plays a part in influencing behaviour in the absence of direct knowledge, then this was evidenced by Paul and Ms Kelangi initially

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[130] Section 70 *Coroners Act 2008.*

[131] Save for Mrs Ginn who received some acknowledgement from Mr Gary Cole after she initiated email contact – Inquest Brief @ p 141.

[132] The written outline of submissions was not formally tendered but can be considered to form part of the Brief – Exhibit 34.

[133] Transcript of proceedings for 17 July 2015 @ p 6. It should be noted that Belgravia Leisure's contact with the witnesses only occurred at the Inquest after they had given evidence: see for example - Steven Ginn @ T p 30; Lina Khaldie @ T p 189.

holding hands in the water and holding onto the side of the pool until they felt a bit more confident about their surrounds. But I doubt they had a real appreciation of the risk of getting out of their depth by the fact that they just did not have the experience of water. The staff at WaterMarc were disadvantage because they had no knowledge of Paul and Ms Kelangi's inexperience. They were but two of the many patrons in the 50 metre pool on this very busy day. Duty Manager De Pasquale said that he did believe that it was a realistic expectation of WaterMarc that patrons should inform them about their swimming limitations. He said that he had numerous patrons do so as well as patrons informing him of medical conditions such as epilepsy and asthma – conditions that could compromise their safety in the water.[134] Duty Manager De Pasquale's expectation however relies on a presumption that all people have the same capacity to recognise their own limitations in or around large bodies of water. The drowning of Paul and Ms Kelangi should however inform Belgravia Leisure the presumption cannot be relied upon and consideration should be given on how to capture the attention of those patrons who do not initially think to inform staff of their limitations. The effectiveness of a sign asking patrons to speak to a lifeguard was questioned. However, I consider that such signage may play a prevention role within and alongside the myriad of other prevention tools and policies and procedures undertaken at WaterMarc.

2. Duty Manager De Pasquale was adamant in his position that the 50 metre pool was being supervised during the movement of the boom and thereafter when it became apparent that the boom would need to be refloated in order to seat it into position. He attempted to deflect this responsibility to Lifeguard Chong, stating that even if he did not directly tell Lifeguard Chong that it was his responsibility, which he did not concede, Lifeguard Chong should have known that the role of supervising the pool defaulted to him. It was difficult to reconcile Duty Manager De Pasquale's evidence with that of Lifeguards Chong and Ramsay. Lifeguard Chong said he was not directed to supervise the 50 metre pool after the boom had been returned to the deep end of the pool but was not yet seated, and he did not have the 50 metre radio handed over to him from Lifeguard Ramsay. Lifeguard Ramsay concurred that he had not handed the radio over to another lifeguard. Ultimately, Duty Manager De Pasquale had the responsibility to ensure the 50 metre pool was being supervised. It was Duty Manager De Pasquale that interrupted the routine supervision of the pools by directing the return of the boom before closing time. By accepting this role of responsibility, Duty Manager De Pasquale cannot divest his overall responsibilies to manage the other lifeguards and ensure that the patrons are safe and being supervised. Ultimately, I was not convinced that Duty Manager De Pasquale had the level

[134] T @ p 127.

of knowledge of the movements, positions and responsibilities of his lifeguards at or around the time of the moving of the boom and the drowning of Paul and Ms Kelangi that equates to appropriate management of his staff. I do however accept that attending Court to give evidence at an Inquest is confronting and at times lends to the temptation to reconstruct events with the benefit of hindsight. This is not to suggest that such reconstruction is done intentionally or with the aim of misleading the Court. I accept that at all times on 2 February 2014, Duty Manager De Pasquale was attempting to discharge his duties as a duty manager. It was however a Sunday, a very hot day in peak season, and extremely busy, and Belgravia Leisure did not provide him with on-site senior management support.

3. Much emphasis was placed on WaterMarc's compliance with lifeguard to patron ratios on 2 February 2014. Lifeguard Burgess considered the ratio of one lifeguard per 100 patrons to be *ridiculously high.*[135] Lifeguard Chong also believed it was a lot of responsibility to give one lifeguard – *to rely on one lifeguard to watch 100 people.*[136] Lifeguard Burgess was of the view that *it is ridiculous to think that they can supervise 100 people and that lifeguards actually provide a false sense of security for the swimmers in the centre.*[137] Moreover, Lifeguard Burgess also said that at the time, lifeguard(s) assigned to watching a pool were also allowed to do other duties *such as like lap ropes and fix signs and things like that.* [138] To allege compliance with the ratio on the basis of numbers only is meaningless if lifeguards included in the ratio do not have their full attention on the actual job and responsibilities of watching over and out for patron safety in and around the pools. If such a situation is not intended by the ratios prescribed in The Guidelines for Safe Pool Operations (**GSPO**) developed by the Royal Life Saving Society Australia, my concern is that they are not rigorously implemented or enforced. Compounding the uncertainty or lack of confidence that I have in relation to the ratio implementation is the reliance placed on lifeguard estimation of the numbers of patrons present in the aquatic centre and indeed in the pools. The confidence of individual lifeguards, including Duty Manager De Pasquale to accurately estimate patrons did not bear out in the evidence. Similarly, Mr Cole's retrospective analysis of the CCTV footage from the reception area reflected that at 7.00 pm on 2 February 2014 there were 514 patrons in the aquatic area and 307 by 7.30 pm[139]. This evidence did not provide any greater certainty as to how many patrons were in the water and

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[135] T @ p 265

[136] T @ p 291.

[137] T @ p 269.

[138] T @ p 272.

[139] Exhibit 27 – Statement of Gary Cole dated 3 September 2014.

was not in any event a system used for informing lifeguards as to the required number of lifeguards needed at any one time.

4. There were no issues in respect of the qualifications of the seven lifeguards on duty on the afternoon/evening of 2 February 2014; each of them had completed the appropriate training to qualify as a lifeguard. The average age of the lifeguards on duty that day was 18.7 years. There was little criticism of how the lifeguards responded to the emergency situation. Mrs Khaldie was concerned about the way they handled the situation stating that they looked *like the lifeguards did not know what to do, it looked like they were in shock.*[140] She said *no one was in control.*[141] Mrs Ginn also raised concern about the Duty Manager's co-ordination of the emergency.[142]

5. I commend the patrons who responded to the emergency situation that arose at WaterMarc on 2 February 2014. Without the prompt actions of patrons to rescue and instigate resuscitation of Ms Kelangi, the outcome for her may have been different. There was similarly a prompt response by Mr Ginn to dive into the pool to rescue Paul. The involvement of Mrs Ginn, Dr Rumbergs and other patrons in attempting to resuscitate him was nothing short of heroic. Unfortunately, the time Paul was submerged in the water acted against his rescuers. While some of the evidence from, in particular, Mr and Mrs Khaldie about the performance of CPR on both Ms Kelangi and Paul, differed from the evidence of other witnesses, it is not necessary to make specific comment on the weight I attach to each of their evidence as I am satisfied that CPR *per se* was initiated promptly and performed proficiently.

Subsequent review

6. In concluding my investigation, I asked the Coroners Prevention Unit (**CPU**)[143] to review how public swimming pools operate and how they are regulated in Victoria. The CPU collaborated with Life Saving Victoria (**LSV**) to compile the review.

7. The central advice in the review was that while a range of different organisations contribute to the operation of public swimming pools, no central body is responsible for establishing and upholding consistent standards (including safety standards) across the industry. Furthermore,

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[140] Exhibit 13 – Statement of Lina Khaldie dated 22 February 2014, T @ p 185.

[141] T @ p 177.

[142] T @ pp 45 - 47.

[143] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

public swimming pool operations are not subject to any meaningful regulatory oversight regarding safe practices and safety standards. For transparency, I have attached the report of the CPU and LSV joint review to this finding (**APPENDIX I**).

8. The review also identified that of the 14 confirmed and suspected drowning deaths at Victorian public swimming pools between 2000 and 2015, seven occurred in the years 2014 and 2015.

9. In this context, it is timely to consider whether a central body is needed to coordinate and oversee public swimming pool operations including safety standards; and furthermore whether this body should be given regulatory powers to perform this role, similar to the powers that underpin the Code of Practice For the Design, Construction, Operation, Management and Maintenance of Aquatic Facilities managed by the Western Australian Department of Health.

FINDINGS

1. I find the identity of the deceased is Paul Daniel Rayudu, born 24 April 1991 and that his death occurred on 8 February 2014 at the Austin Hospital, Heidelberg.

2. I accept and adopt the cause of death as ascribed by Dr Joanne Glengarry and I find that Paul Rayudu died from hypoxic ischaemic encephalopathy as a consequence of immersion/drowning that occurred on 2 February 2014 at WaterMarc Aquatic Leisure Centre in Greensborough.

3. AND I further find that at the time of the drowning of Paul, the 50 metre pool at WaterMarc was not being supervised by a lifeguard or lifeguards dedicated to that pool. The presence of Duty Manger De Pasquale, Lifeguard Sheridan and Lifeguard Chong did not constitute effective supervision of the 50 metre pool, as I find that these lifeguards were all distracted by the difficulties they were experiencing in seating home the boom at the deep end of the 50 metre pool. In finding that Lifeguard Chong was distracted with this activity, I find that he was not designated the responsibility to supervise the 50 metre pool either by direction from Duty Manager De Pasquale or implicitly, because he had not been handed the 50 metre pool radio which is, in the normal course of events, part of the process for handing over responsibility for that pool when the lifeguards rotate around the various pools.

4. I am unable to make definitive findings about the exact circumstances in which Paul came to drown at this public swimming pool, as the only direct witness, his partner and swimming companion, Ms Kelangi has no direct recollection of the immediate surrounding circumstances. There is however clear and cogent evidence to make findings on the balance of probabilities that Paul was an inexperienced swimmer; Paul was "swimming" and/or frolicking in the water with Ms Kelangi in the vicinity of the drop off zone; Paul was in the vicinity of the drop off zone at the time the boom was moved and that the movement of the boom away from the drop off zone creates the "drop off" or sudden and significant change of depth of the water and that this

sudden and significant change of depth of the water would have immediately placed Paul out of his depth; the combination of which I find are the contributing factors to his drowning.

5. The weight of the evidence supports a finding that once the lifeguards were alerted to the drowning of Ms Kelangi and the subsequent discovery of Paul, they individually and collectively implemented their lifesaving training. The evidence supports a finding that the lifeguards involved in the resuscitation of Ms Kelangi and in the resuscitation attempts of Paul, acted professionally and in accordance with their training and I commend them for the same.

6. Whilst I acknowledge that the signage around the 50 metre pool and in particular the signage depicting the drop off zone was subject to audit and approval by Lifesaving Victoria before WaterMarc opened some two years earlier, it is not possible to say how effective the signage has been in informing patrons of the actual dangers associated with that area within the 50 metre pool. From the known circumstances in this Coronial investigation I find that the signage played no part in deterring Paul and Ms Kelangi from playing around that area. In implementing additional safety measures around the movement of the boom that Mr Russell informed me of at the outset of the Inquest, I interpret these changes to procedures at WaterMarc, albeit that they were not contemporaneous to the drowning of Paul, as an acknowledgement by Belgravia Leisure that signage is in itself not sufficient to inform the patrons of the potential dangers of the drop off zone and signage and supervision by dedicated lifeguards might not be sufficient to protect vulnerable patrons of the dangers of the drop off, particularly when the boom is moved while patrons remain in the pool. Designating a lifeguard *to the drop off zone to stand there at the time* of the movement of the boom and the placement of an extra set of tubing or barriers around that delineated area as the boom moves away, are preventative measures. While they were not specifically stated to be in response to Paul's death, I have interpreted them to be so given the timing of the reassessment and announcement of the same.

7. I find that Belgravia Leisure Pty Ltd has implemented appropriate changes to procedures surrounding the movement of the boom that are in response to the circumstances of Paul's death and that they have been implemented with the aim of preventing like deaths. Additional changes to the location of the defibrillator, the purchase of materials to create a dry environment on the pool deck for use of the defibrillator, training, rostering of an additional lifeguard as a "Runner" and the rostering on a more senior member of management during the busy months to provide support to pool staff, are similarly acknowledged and welcomed as preventative measures.

8. In light of the number of recent Victorian drowning deaths in public swimming pools, I find the lack of central oversight and regulation of public swimming pool operation in Victoria is concerning. While I am satisfied that Belgravia Leisure Pty Ltd has made changes to its

practices to improve patron safety, the lack of such a central body could mean that the lessons learned from Paul's death and the deaths of others might not effect appropriate change in the operations of other public swimming pools.

9. Ultimately I am obliged to turn my mind to whether, on the balance of probabilities, the death of Paul Rayudu was preventable. On the weight of the evidence I am satisfied that there is clear and cogent evidence, albeit that it is multi-faceted, to support such a finding that the death of Paul Rayudu could have been prevented. No one should drown at a public pool.

RECOMMENDATIONS

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

1. With the aim of supporting access to a safe aquatic environment while reducing harms and preventing like deaths through improving the knowledge base of Duty Managers and lifeguards about patrons with inexperience/vulnerabilities in water or who are non-swimmers, **I recommend** that Belgravia Leisure Pty Ltd implement a system, not limited to, but which may be in the form of signage, requesting patrons to inform a staff member of their vulnerabilities before entering the water.

2. With the aim of supporting access to a safe aquatic environment while reducing harms and preventing like deaths through improving the knowledge base of Duty Managers and lifeguards about patrons with inexperience/vulnerabilities in water or are non-swimmers, **I recommend** that Belgravia Leisure Pty Ltd in consultation with Banyule City Council explore the options and means for best communicating with and encouraging patrons who have English language challenges, to inform a staff member of their vulnerabilities before entering the water. The communication option may take the form of, but not be limited to, visual imagery on a monitor at the Reception area and multi-lingual written material.

3. With the aim of promoting public health and safety and preventing like deaths in public swimming pools, **I recommend** that Chris Eccles, Secretary of the Department of Premier and Cabinet, work with the appropriate area of Victorian government to establish a central oversight and regulation body for public swimming pool operation in Victoria, to ensure safety standards are applied and upheld consistently across the industry.

To enable compliance with sections 72(5) and 73(1) of the *Coroners Act 2008* (Vic), I direct that these Findings will be published on the internet.

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

- Mr Paul V Rayudu
- The Consulate General of India, Melbourne
- Mr Sreekanth Pampana
- Ms Virajitha Kelangi
- Maddocks Lawyers
- HWL Ebsworth Lawyers
- Life Saving Victoria
- Royal Life Saving Society of Australia
- Belgravia Leisure Pty Ltd
- Mr S. Russell of Counsel
- Banyule City Council
- Mr F. Scully of Counsel
- Victorian Workcover Authority
- Mr A. Imrie of Counsel
- Mr T. Fitzpatrick of Counsel
- Mr R. O'Neil of Counsel
- Mrs M. Ray of Counsel
- D/L/S/C Emma Bennett

Signature:

AUDREY JAMIESON
CORONER
Date: **18 August 2016**

APPENDIX I

Drowning at Public Swimming Pools Review

Coroners Prevention Unit & Life Saving Victoria

Coroners Court of Victoria

Coroners Prevention Unit Advice

Attention:	Coroner Jamieson
cc:	Coroner English
From:	Lyndal Bugeja and Ashne Lamb, Coroners Prevention Unit (CPU)
	Bernadette Matthews, Life Saving Victoria
Date:	8 August 2016
Re:	Drowning at public swimming pools
Case:	20140761 – RAYUDU
Keywords:	drowning; public swimming pool

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1. Background

1.1 Coroner's Request

Coroner Jamieson requested that CPU provide statistical information regarding public pool drowning, including any common issues and recommendations made by other Coroners. This report was compiled in conjunction with the Aquatic Risk and Research Department, Life Saving Victoria (LSV).

To contextualise the request, the CPU sought information about the operation and regulation of public swimming pools in Victoria.

2. Victorian Public Swimming Pool Operation and Regulation

2.1 Aquatic Industry Guidelines for Safe Pool Operation

The Royal Life Saving Society Australia (RLSSA) performs a key role in developing and communicating safe practices in and around aquatic environments. In relation to public swimming pools they produce the Guidelines for Safe Pool Operations (the Guidelines). Life Saving Victoria (LSV) is the State branch of the RLSSA and offers Pool Safety Assessments (PSAs), Training and Education services, consultancy and Industry support and development services.

The Guidelines were developed in the early 1990s and the last review (covering three Sections) took place in April 2013. While they do not function as legislation or regulations, public swimming pools should operate in accordance with the Guidelines as they are recognised by the industry as best practice.

The Guidelines are split into seven sections covering:

- General Operations
- Technical Operations
- First Aid
- Facility Design
- Supervision
- Aquatic Programs (Learn to Swim) and

- Low Patronage Pools.

Details of key applicable guidelines is contained in Attachment A.

2.2 Guidelines for Safe Pool Operation Review

In November 2014, RLSSA produced the 'Guidelines for Safe Pool Operations Review Report.' The report set out the need for (and intention to) complete a full review of the scope and content of the current Guidelines. Following this a 'Terms of Reference – National Reference Group' document was also developed and circulated.

A review committee was put together based on the two documents and a two day meeting occurred in Victoria on 26 and 27 February 2015. The Guideline review is currently underway and is being coordinated by RLSSA.

2.3 Pool Safety Assessment

In May 2014, LSV progressed from the existing Aquatic Facility Safety Assessment to the Pool Safety Assessments (PSAs). A PSA is intended to provide an independent assessment on a swimming pool's safety provisions and provide guidance on improvement opportunities.

The objectives of conducting a PSA are to:

- Improve swimming pool safety standards
- Provide a structured and systematic process to assessing
- Demonstrate the use of a formal risk management process
- Ensure referenced based assessment content
- Deliver clear and consistent reports and risk treatment plans
- Provide practical solutions to identified challenges
- Offer endorsement to best practice facilities
- Encourage industry engagement, discussion and understanding
- Supporting the training and educational needs of facility reps
- Ensuring access to updated information and advice
- Enabling facility benchmarking against the aquatics industry
- Maintaining a working relationship with the States peak body

Two scores are provided for facility assessments:

- The 'Safety Score' is the overall score achieved from all assessed components of the PSA. The calculation is the total score achieved by the facility (safety denominator) divided by the total number of assessed items (Safety Indicator).
- A 'Compliance Score' is also provided which is the score achieved by the facility from all assessed components of the PSAs which have been identified as compliance items. Compliance items are those which have been identified by LSV as directly relating to key areas of risk, whilst excluding those that require substantial capital investment to treat. Therefore, facility design items are less likely to be compliance items than administration items.

The PSA has been designed to enable all facilities to establish both: (a) their overall level of operation against best practice (Safety Score); and (b) the opportunity to achieve 100% in the key risk items directly within their control (Compliance Score).

2.4 PSAs and the State of Industry Report

On an Annual basis a State of Industry Report is developed. This was last completed for the 2013-14 financial year period. The report is based on results from the 74 public aquatic facilities that underwent safety assessments during this time. These represent approximately 25% of the industry, which is a marginal increase on the 2012/13 proportion.

This demonstrates a need to increase awareness of the importance of aquatic safety and the services that are available to assist facilities in improving the safety provisions at individual facilities.

Of the approximate 300 public swimming pools in Victoria LSV understand that:

- Approximately 10% undertake the PSA process on an annual basis
- An additional 10% undertake the PSA process on a bi-annual basis
- 47% haven't undertaken a PSA in the last 5 years
- 30% haven't undertaken a PSA in the last 10 years

LSV and RLSSA recommend that the PSA process be undertaken every two years in order to achieve the objectives set out above. There is evidence that the more frequent facilities undertake the assessment process the higher they score. Higher scores imply improved level of standards at the facility and an increased likelihood that the facility is providing a safe environment for patrons and staff. The cost of conducting this assessment is currently $1550.

LSV believes that the PSA process should be considered as part of the performance criteria or part of management contractual requirements. This would provide facility owners, for example Local Government, with an independent evaluation of the contract manager's compliance to industry best practice.

3. Drownings at Victorian Public Swimming Pools

3.1 Method

Unintentional drowning deaths that occurred at Victorian public swimming pools between 2000 and 2015 were identified and verified by searching the Coroners Prevention Unit Surveillance System and the National Coronial Information System, using the following criteria:

- The cause of death was drowning.
- The drowning occurred at a public swimming pool, which was defined as a leisure or recreational venue including one or more swimming pool facilities which is owned by a Victorian Municipal Council.
- The death was investigated by a Victorian coroner between 1 January 2000 and 31 December 2015.

For deaths that met the inclusion criteria, the CPU recorded the following information into Microsoft Excel to create a unit record dataset:

- local case number (LCN)
- year incident occurred
- month incident occurred
- age
- sex

- facility name
- facility location
- contributing factors
- coroners recommendations

A series of univariate descriptive statistical analyses were performed to generate frequencies and proportions on: trends over time; socio-demographic profile of persons who drowned; and the location of the drowning. A content analysis was also performed on the coroners' findings to identify contributing factors. Coroners' recommendations were extracted and reviewed to identify common themes.

3.2 Relevant deaths

During the 16 year period, 14 Victorians drowned in aquatic locations defined as public swimming pool. A further death occurred at an overseas location and was excluded. The major of deaths were of males (n=12) and ages ranged from 2 to 78 years. The deaths are summarised in Table 1.

Table 1. *Unintentional drowning deaths at public swimming pools, Victoria 2000-2015*

Year	Month	Age	Sex	Name of Facility	Location
2000	November	2	Female	Footscray Swim Centre	Metropolitan
2001	October	78	Male	Classic Residences Retirement Village	Metropolitan
	December	4	Male	Kyneton Bushland Resort	Regional
2003	February	27	Male	Bairnsdale Aquatic Centre	Regional
2007	December	66	Male	East Keilor Leisure Centre	Metropolitan
2009	April	31	Male	Input Fitness Health Club	Metropolitan
2010	January	6	Male	Lancefield Memorial Pool	Regional
2014	February	22	Male	Watermarc	Metropolitan
	March	51	Male	Benalla Aquatic Centre	Regional
	July	54	Male	Ascot Vale Aquatics Centre	Metropolitan
	August	26	Male	Grand Chancellor Hotel	Metropolitan
2015	April	50	Male	Casey Recreation and Aquatic Centre	Metropolitan
	July	53	Male	Maribyrnong Aquatic Centre	Metropolitan
	December	20	Female	Orbost Swimming Pool	Regional

3.3 Contributing factors

Among the 14 deaths, the following contributing factors emerged from CPU review of the summaries of circumstances:

- **Supervision.** Among the three drownings of children under 10 years, caregiver supervision was determined by the Coroner to be absent immediately prior to immersion. In two of the three, lifeguards were on duty but did not observe the child in time to successfully perform CPR.

- **Alcohol.** Toxicology was performed in 12 of the 14 cases, one where the deceased's blood alcohol concentration was detected at a level greater than 0.05g/100ml (20156489.[1]
- **Pre-Existing Illness.** In four of the 14 cases there was some evidence of a pre-existing medical condition, specifically a heart condition. It was difficult for the forensic pathologist to determine whether the underlying condition contributed to the immersion incident or was a co-occurrence.

3.4 Summary of results and limitations

The current study consisted of an examination of Coroner's findings to identify factors related to incidents of drowning at public swimming pools over time. Fourteen deaths were identified during the period 1 January 2000 and 31 December 2015. In the majority of cases the deceased was male (86%) and just over half occurred at metropolitan facilities (65%). In nine of the 14 cases at least one contributing factor was identified relating to: absence or inadequate supervision (n=5), pre-existing medical conditions (n=4); and alcohol impairment (n=1).

The current study was limited to an examination of Coroner's findings (as opposed to the entire coronial files containing a full brief of evidence, including witness statements). It was also not possible to determine the exact chain of events leading to the incident in every case as the deceased had attended the facility on their own and/or there were no witnesses to the immersion incident.

4. Prevention opportunities

Despite these limitations, it was clear from the investigations that drowning deaths at public swimming pools, like unintentional drowning deaths at other aquatic locations, were preventable. In the past, Victoria's Coroners have formulated a number of recommendations to redress issues that have emerged from these incidents, many of which have been taken up by the aquatic industry. These recommendations are contained in Appendix 2. The CPU notes that the most recent Victorian Coroner's recommendations directed at safety of public swimming pools was for a 2003 death. The following are some further prevention opportunities of which the CPU is aware.

4.1 The importance of supervision

The aquatic industry needs to ensure that lifeguards are aware of their primary role as pool supervisors and exactly what constitutes adequate supervision. The industry also needs to take into account the profile of the lifeguards employed. They are often young students working on a casual or at most part-time basis to support themselves while studying. Literature produced by the industry also indicates that turnover of aquatic staff is high.[2] The management of individual facilities also often has high turnover with some management contracts being as short as 12 months. The high turnover at a front line and management level reduces the facility specific knowledge and consistency of standards / processes delivered.

4.2 Industry Feedback, Integration and Communications

The requirement to engage and communicate with the Victorian aquatic industry in all areas of interest is more vital than ever. This is based on the continually changing social, economic and political environment within which the facilities operate. In Victoria this task is predominantly driven by LSV and Aquatics and Recreation Victoria

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1 Note this matter is still under investigation.

2 Life Saving Victoria, <http://www.lifesavingvictoria.com.au/www/html/1358-play-it-safe-by-the-water.asp?intSiteID=1>, accessed 10 August 2016.

(ARV). The following are current industry provisions which include elements of swimming pool safety.

- Pool Safety Summit (LSV) – Annual
- Safer Pools Newsletter (LSV) – Quarterly
- Facility Management Design Committee (ARV) – Quarterly
- Operations Coordinators Committee (ARV) – Quarterly
- ARV Conference (ARV) – Annual
- Australian Leisure Facilities Association: Industry Updates – Weekly

There are a number of additional groups, committees, peak bodies, government agencies and independent organisations who contribute, support and engage with the public swimming pool industry. A single central point of reference for public swimming pool safety is recommended. It is proposed that the GSPO Review Working Party become the platform for this.

It is also proposed that this group is linked to the broader water safety education and public awareness committee in the State. In Victoria this is Play It Safe by The Water (PISBTW). This campaign is actively working towards increasing community awareness of water safety information to assist safety across all aquatic environments (from the beach, river, pool and home) and across all aquatic activities (from swimming to boating and fishing).

4.3 WorkSafe

As the State body for workplace health and safety WorkSafe Victoria are recommended to also play a role in this process. WorkSafe are the sole agency with the ability to administer, inform, deter, inspect, enforce and prosecute and it is vital that they work in partnership with the industry towards common safety objectives and measures.

WorkSafe are required to be advised of all 'notifiable incidents' at a workplace and have enforcement powers exceeding those of any other current key stakeholders. It is perceived that their input at a preventative level could prove invaluable to the industry, increase understanding, improve communications and assist in engaging those swimming pools not currently engaged.

4.4 Industry Benchmarking

Industry benchmarking for public pool safety standards has historically been limited to the State and National 'State of Industry' report. The Department of Planning and Community Development have recently trialled a revised 'Local Government Performance Reporting Framework and Indicators' program. The framework is a mandatory system of performance reporting to ensure Councils are consistently reporting on performance.

A section on Pools is a welcome inclusion within this process with the section objective to provide safe, accessible and well utilised facilities. The safety quality indicators are understood to be:

- Days lost due to water quality / Total available days of operation
- Number of water safety incidents / Total number of visits to the facility

Although these measures are useful, they do not go far enough to investigate the safe operation of public pools. Given the importance the exposure of the pools (number of visits per year) alternative measures are recommended and it has been proposed previously by LSV that the PSAs would be an appropriate benchmark for

this purpose, based on the comprehensive assessment content, the risk management process and that fact that it is already known to the industry.

4.5 A Legislated Approach

Unlike any other State, public swimming pools in Western Australia are subject to the requirement set out in the 'Code of Practice – For the Design, Construction, Operation, Management and Maintenance of Aquatic Facilities'. The document is managed by the Western Australia Department of Health and contributes input to over twenty Organisations and individuals. It is the best example of a consultative State based approach to public pool safety within Australia.

The document mandate includes requirements in areas including chemical safety, water quality, special features, signage, sanitation and qualification requirement. Conceptually the document content is similar to the GSPO, however as legislation it has a far greater impact and influence on the industry.

4.6 Facility Design

The design of public swimming pools continues to evolve and is being driven by a number of components including (but not limited to):

- the need for Councils to provide appropriate infrastructure to ever changing communities
- a need to respond to increasing health issues within communities
- a raised awareness of the benefits of active and healthy communities
- pressure, demand and support of sporting clubs and local communities
- an increase importance within Council strategic plans and
- the capabilities of architects and builders to create great community facilities.

The GSPO has a Section specific to Facility Design which provides a range of information and advice which relates predominantly to a facility being operationally safe. There are often two key challenges. The first is that the surveyors, architects and builders do not operate swimming pool facilities. As a result they do not in all instances fully comprehend the operational requirements of facilities, although significant work in this area has occurred with some organisations. The second is that there is currently no formal capacity for the requirement of the GSPO to be considered, let alone enforced through the design and build process. When these two considerations are combined with the high turnover of facility management individuals and organisations there is often limited knowledge at an operational level regarding what is the best way to safely run this facility based on its specific design.

4.7 Compulsory Competitive Tendering (CCT)

This document is not intended to investigate the impact of the introduction of CCT on the operation and safety of public swimming pools. However, it may be beneficial for this piece of research to take place to enable a better understanding of the implications of this process. There are a number of key considerations which given the nature of the industry may be having a negative effect on facility safety.

For example, staff costs are known to make up a significant proportion of overall facility operating costs within the industry. As such to increase the appeal of an Organisation's tender bid to a Municipal Council, facility operators have to be cognisant of the financial components. This may lead to areas such as pool supervision being based on minimum standards rather than best practice. This could be a direct result of the existing guidelines having no current formal legal standing and therefore leading to limited or no enforcement provisions being in place.

4.8 Risk Management

In 2009, ISO 31000 (Risk Management) was introduced as the recognised standard for risk management. The standard is based on Australian Standard AS3460 (Risk Management) and has changed the risk assessment approach into a broader risk management process by providing a more holistic structure and framework. The International Organisation for Standardisation website details that "managing risk effectively helps organisations to perform well in an environment full of uncertainty".

Given the dynamic nature of the aquatic industry and the staff makeup the safety assessment services delivered by LSV have identified gaps within the areas of formal risk management (design, implementation and documentation). More work is required in this area to educate, support and enforce the requirement for facilities to base day-to-day and strategic operation on sound risk management principles in order to raise overall safety standards and achieve the benefits associated with the approach.

5. Conclusions and Recommendations

The CPU analysis of public pool drowning deaths revealed that these deaths were preventable. Prevention is considered to be based on two key principles:

- a combined supervision effort between parents / guardians and facility lifeguards
- a structured and communicated approach and commitment to water safety

A range of opportunities are also available to improve safety at public swimming pools:

- Consideration of a legislated approach to public swimming pool safety to cover key operational components (based on the Western Australia model).
- Involvement of WorkSafe within the industry as a preventative and enforcement agency.
- Development of a single central Victorian public swimming pool register to ensure industry communications is accurate, up-to-date and all-encompassing.
- A process to centralise and mandate the delivery of PSAs across all Victorian public swimming pools.
- Government support and involvement in the GSPO review to ensure a central and up-to-date structured approach to guidance is provided to the industry
- Increased support for the continued development / role out of the Watch Around Water parental supervision program across Victoria.
- Involvement of WorkSafe within the industry as a preventative and enforcement agency.
- The increased involvement of Local Government through the inclusion of appropriate safety benchmarking in the 'Performance Reporting Framework'

Attachment A – Key Applicable Guidelines

Lifeguard Qualifications

SU5 Accreditation for Pool Lifeguards

4.2. Qualifications:

(a) The appropriate minimum qualification for a pool lifeguard/pool attendant is the RLSSA Pool Lifeguard Award including units of competency SRCAQU003B, SRCAQU006B, SRCAQU007B and PUXEME01A or equivalent, as delivered by a Registered Training Organisation (RTO).

(b) The RLSSA Pool Lifeguard Award is current for a period of twelve months and should be re-assessed by an external RLSSA Pool Lifeguard Assessor or equivalent on an annual basis.

(c) Other qualifications as required by State/Territory regulations.

Staff Inductions

SU7 Lifeguard Induction and In-service Training

4.1. Frequency:

(a) All lifeguards should receive a facility-specific induction before commencing work as a lifeguard.

(b) Employers should keep a record of the date and content of all staff inductions.

4.2. Content:

(a) The content of induction sessions should be facility-specific and should include, but not be limited to:

- demonstrating/outlining the application of the organisation's OH&S procedures
- demonstrating/outlining the application of the organisation's Emergency Action Plan (EAP)
- supervising clients at an aquatic facility or environment
- familiarisation with the facility and its staff
- guarding positions
- facility-specific signals and rules

In-service Lifeguard Training

SU5 Accreditation for Pool Lifeguards

4.3. Facility Specific Training:

As every aquatic facility has its own design, format and emergency procedures, lifeguards should be instructed on elements which are specific to the facility in which the lifeguard is to work.

SU7 Lifeguard Induction and In-service Training

5.1. Frequency:

(a) Lifeguards working in a seasonal pool should participate in the in-service training just prior to the start of the season and one at least every three months there after until the close of the season.

(b) All other lifeguards should participate in a minimum of four organised training sessions per year to ensure maintenance of necessary skills and competencies.

5.2. Facility Specific Training:

(a) Training sessions should be held at, or relate directly to, the aquatic facility

in which the lifeguard is employed.

(b) An exception to this may be in relation to the theoretical or general practical activities e.g. oxygen equipment or resuscitation training.

Supervision – Generic

SU1 Bather Supervision

5.1. Minimum on Duty:

(a) A minimum of two people should be on duty at any one time.

(b) At least one person should be a qualified lifeguard to the RLSSA Pool Lifeguard standard or equivalent and be capable of supervising the water.

(c) The second person, qualified to a minimum of a current RLSSA Bronze Medallion, should be on site and easily contactable in an emergency.

(d) At least one of these people should be qualified with a Level 2 (Senior) First Aid qualification and be available for the provision of first aid services.

5.2. Minimum Supervision:

(a) A minimum of one qualified lifeguard should be supervising, facing and watching the people in the water at all times.

(b) Sufficient lifeguards should be provided to ensure that all the body/s of water and people therein can be supervised effectively.

(c) Lifeguards are responsible for the supervision of all patrons within the aquatic areas of the facility, including those children under parental supervision.

5.4. Ratios:

(a) The recommended minimum ratio of lifeguards to people in the water is 1 lifeguard for up to 100 people.

SU4 Description of Lifeguard Duties

The duties of lifeguards are those specifically identified as necessary for the prevention of injury and the saving of life. Such duties will normally be undertaken by lifeguards who may also be required to fulfil other tasks such as customer service, cleaning and maintenance activities. However, while rostered for direct pool supervision the lifeguard should focus entirely on the safety of people in or around the water.

Supervision – Facility Specific

SU1 Bather Supervision

5.4. Ratios:

(b) A risk assessment should be completed by facility operators prior to establishing lifeguard ratios. Refer Guideline GO7 Risk Management In Aquatic and Leisure Centres for details.

(c) Facility operators should consider a range of factors such as, but not restricted to

- weather
- holidays
- size, number, and layout of pools

- surface reflection
- average attendance
- anticipated attendance
- swimming capabilities
- special needs individuals and groups
- the number and distribution of users
- recreational activities, either programmed or spontaneous

SU1 Bather Supervision

5.5. Ratios For Other Facilities:

(a) Multiple/Irregular Shaped Pools. Sufficient lifeguards should be provided to effectively supervise the surface areas of all pools within the facility. All areas of the pool including the pool floor must be scanned and scrutinised on a regular basis.

(b) Wave Pools (refer also Guideline SU14). The recommended minimum ratio of lifeguards to people in the water during wave motion is 1 lifeguard for up to 40 people.

Emergency Procedures

G02 Emergency Action Plan

The minimum safety content of an emergency action plan should include details on the following:

4.2.1. Routine aquatic emergency procedures:

a) Minor incident

b) Overcrowding

c) Disorderly behaviour

d) Lack of water clarity

e) Chemical irregularities.

4.2.2. Major Incidences:

Incidents considered to be life threatening for any and all individual including:

a) Suspected drowning

b) Suspected spinal injury

c) Cardiac incident

d) Chemical spill or leak.

Safety Signage

FD3 Pool Depth Markings

4.1. (a) All depth markings should be provided in metric measurements.

(b) If used, it is desirable to provide imperial measurements in brackets next to the metric measurements.

(c) Markings should be in metres, e.g. 0.9m, 1.2m, 1.5m, 1.8m, 2.0m.

4.2 The markings should be in numerals and letters at least 100mm in height.

4.3 Markings should be placed in a position where they can be seen from the water and from the pool side.

4.4 The number and location of depth markings will vary dependent upon the size and configuration of the pool. However there should always be depth markings at the shallow end and deep end, and additional markings along the length of the pool, as necessary to be visible from all areas inside the pool and the surrounding concourse.

4.5 Any sharp change in gradient should be clearly marked and sign posted. (refer also Guideline FD1).

4.6 (a) In shallow water - 1.2m deep or less - the words CAUTION SHALLOW WATER and Australian Standard Shallow Water symbol (Sign WS,31 in the National Aquatic & Recreational Signage Style Manual) should be displayed.

(b) Additionally, in water less than 1.8m for "wet-deck" pools or less than 2.0m for pools with surrounding walls greater than 380mm above the water level, Australian Standard "No Diving" (Sign R18 in National Aquatic & Recreational Signage Style Manual) signs as well as the words NO DIVING should be displayed. (refer also Guideline FD4, FD6 and FD 8).

4.7 (a) All pool depth markings should be of a strong contrast against the surrounding areas.

(b) Pool depth markings should be installed to minimise fading or damage from bather traffic or from cleaning.

Lifeguards should be aware of the existence of the Guidelines and where a copy of the Guidelines are located at the facility. Furthermore they should be familiar with the particular Guidelines which address their day to day responsibilities, such as supervision.

Aquatic managers should also be familiar with the Guidelines relevant to their day to day activities and the activities of those staff members under their management. In order to do this, aquatic managers should be able to provide information to their lifeguards on what information the Guidelines contain and ensure that the Guidelines are available as a reference at all times. To maintain and increase the level of knowledge of aquatic managers, RLSSA should develop additional training material, including assessment, on the more technical aspects of the relevant Guidelines.

Attachment B – Coroners' Recommendations

Case Number 20030415 (Coroner Byrne)

A statutory regulatory regime or a hybrid arrangement without an adequate policing and enforcement capacity is very much a "toothless tiger". Research clearly shows the strongest motive to ensure compliance with a regulatory regime is the real prospect of sanctions for non-compliance. It may be that revised/refined RLSSA Guidelines to Safe Pool Operations, in effect, the self regulating status quo, is sufficient. But whilst RLSSA is widely recognised as an extremely pro-active not for profit public health and safety organisation, it has its limitations. For instance, when asked about the organisation's research capacity Mr. Farmer conceded it was "very, very small" in fact he conceded "almost negligible". The scope of this inquest has not enabled me to reach a concluded position as to whether more formal regulation of the aquatic industry is necessary. If the industry is to move from self regulation to full statutory regulation a significant injection of funding would be necessary. I merely recommend a wide ranging review be undertaken to enable the responsible Minister to be adequately advised. Ultimately it is a matter for Government.

Irrespective of what direction the matter takes, the RLSSA Guidelines require immediate attention. Recommendations are included in the Drowning Deaths at Public Swimming Pools, Victoria July 1988- June 2002 (see pages 21-22). As an interim measure I commend and adopt those recommendations with the exception of the age limitation referred to in recommendation 4. Whilst I understand the rationale behind the age limitation, I consider it so restrictive it would assuredly be widely circumvented. :

1) Low Patronage

a. Low patronage should not be defined by region, instead it should be determined solely on usage and design of the facility and once determined is a continuing classification.

b. This assessment needs to be independent and based on the data collected by RLSSA in the SPSA.

c. Classifications could be reassessed bi-annually if funding were received to conduct SPSA on an ongoing basis.

2) Patron Supervision of Diving Pools

a. RLSSA Guidelines should be amended in relation to patron supervision of diving pools to refer to direct/primary supervision of such pools when open for operation. Both lifeguards should also occasionally scan the other pool as well as each other.

b. This issue should be specifically addressed during the Pool Lifeguard course and annual reaccreditation administered by the RLSSA and other registered lifeguard training organisations. This may include a question on the written examination and be addressed in the testing scenarios.

3) Training

a. It is common for lifeguards to work at more than one facility during their lifeguarding career. Some of these facilities may be managed by the same company where policies and procedures are similar. Regardless of this, each facility is unique in terms of its design and patronage. Therefore a thorough induction process should be undertaken by the aquatic manager for each new employee prior to the commencement of the first shift and regardless of their experience."

Case Number 20003758 (Coroner Byrne)

It would seem timely that at the commencement of the summer period a public awareness/education campaign be delivered stressing the need for parental/carer supervision at public pools stating that the "first line defence" rests squarely with parents/carers. The nature of the campaign, that is the approach, should be a matter for those with expertise in "selling" these messages.

As the Guidelines stand, signage stressing the need for parental supervision is merely recommended. I believe this Guideline should be "beefed up". I recommend that appropriate, conspicuous signage be mandatory at strategic locations within the aquatic facility; for example, the entrance, the changerooms and perhaps in the immediate vicinity of the toddlers/teaching pool.

Case Number 20000679 (Coroner Byrne)

I recommend the RLSSA consider reviewing guideline SU 4.5 of the Guidelines for Safe Pool Operations with a view to requiring all lifeguards to carry a resuscitation pocket mask that incorporates an "oxygen nipple" and perhaps also a "mask connection port" incorporating a one way barrier.

Case Number 19991465 (State Coroner Johnstone)

The pool was attended in accordance with the Royal Life Saving Society Australia Guidelines for pools with low volume patronage. The Centennial pool, being small in size would consistently have fewer than 50 patrons in the water at any one time. There is however, a possibility that had a second attendant been on duty and commenced work at the same time the outcome may have been different in that the deceased may have been retrieved from the pool in a shorter time and emergency treatment commenced earlier. While I make no finding of contribution due to compliance with the guidelines, it would appear that consideration should be given to having two attendants on duty at all times.

Case Number 19940150 (State Coroner Johnstone)

Whilst there is a need to balance the requirement that an epileptic partake in as full a life as practicable and that all concerned in this case emphasized this point, there is also a need to address and manage risk.

In this case there appears to have been a lack of consideration of the risk associated with an epileptic fitting in the water environment of a spa. Although exclusion from the "swimming pool" had been considered by the gym the link had not been made to associate the spa with the potential risk of drowning when a person was unconscious.

This appears obvious. From a medical perspective there appears to have been a lack of appreciation that a gym could include a water environment i.e. a spa, pool et cetera, and the most recent warning was linked to the use of "weights".

Generally throughout the inquest the links were not make with the risks using a spa or bath in epilepsy. In a recent finding (3681/90), the Coroner commented on the death of an intellectually disabled patient suffering from grand mal seizures during a bathing routine at a community residential unit:

> "Community Services guidelines were in place at the time of the death and were circulated in community residential units. The guidelines included warnings of the risks of swimming and bathing for people with epilepsy, statistics relating to drowning, guidelines as to the taking of baths and showers and appropriate supervision, and circumstances when baths could be permitted for people epilepsy. In 1990, a further paragraph was added which repeated some of the information already provided, and added that

there had been recent cases of people with epilepsy drowning in community residential units. The paragraph closed with the words:

"It cannot be stressed too strongly that epilepsy and water is a potentially lethal combination requiring caution and vigilance at all times."

There appears to be a need for the risk associated with water and epilepsy (spas, baths, pools et cetera) to be reinforced and regularly drawn to the attention of the patient, family and those operating sporting facilities such as gyms.

It may be appropriate for the Australian Association of Neurologists and the College of General Practitioners to ensure that appropriate information on the risk is made available to the patient. An example of warnings can be seen in the information provided by Epilepsy Foundation of Victoria. The findings should also be sent to the Victorian Institute of Sport, Department of Arts, Sport and Tourism, the Epilepsy Foundation and the Office of Fair Trading.

A copy of the warnings and information provided by the foundation is attached to the finding. Also attached is a review of drowning deaths in people with epilepsy, CA Ryan and G Dowling Canadian Medical Association Journal, March 1993, which provides useful information on seizure related drownings and comments. "They represent a small potentially preventable proportion of all drownings". There may be a need for the fitness industry to assess the issue that arose in this case for the purpose of improved management of epileptics involved in exercise programs where water may be a factor.

Case Number 19910317 & 19910615 (Coroner Heffey)

1. That a Pool Life Guard Award (or a course offering equivalent training) be a prerequisite to employment as a Pool Manager, Assistant Manager or Pool Attendant.
2. That completion of Level 2 in the use and operation of oxygen equipment be a prerequisite to employment as Pool Manager or Assistant Manager. (Level one being included in the basic Pool Life Guard Award).
3. That persons currently answering the description of Manager, Assistant Manager or Pool Attendant be offered training in these courses prior to 1993-1994 season.
4. That municipalities be concerned to:
    i. continually monitor the levels and qualifications of staff engaged at local pools to ensure that qualifications are kept up to date and current, and that refresher courses are offered and taken when appropriate;
    ii. to direct Pool Management:
        a. to devise and implement an emergency plan and to conduct regular on-site training and drills to ensure automatic co-ordinated response to all situations that might be reasonably be expected to arise;
        b. to implement communication systems either by whistles or hand signals or both for both routine messages and emergency situations;
        c. to pay particular attention to staff: patron ratios and to enlist additional staff where appropriate. (It is recognized that no hard and fast rules can be stated to cover all situations however a minimum of two pool attendants should be on duty dedicated to

surveillance at any one time, this being the minimum required to achieve the best resuscitation results);

d. to close the pool or at least clear the water when an emergency arises requiring the attention of pool attendants;

e. to expel from the facility children who pretend to be in difficulties and include this conduct as prohibited on display signs. (This practice was mentioned in both inquests and had some bearing);

f. to set up a system of rotation and breaks for pool attendants such as will relieve tedium and therefore assist concentration;

g. to ensure that uniforms are worn at all times by pool attendants;

h. to recognise and anticipate any dangers that might arise in relation to children or young adults performing "bombs" near other swimmers and to either warn them, relegate them to a particular area or remove them from the pool as is deemed appropriate. The same consideration should apply to floating tyres which ideally should be tethered in some fashion to one area;

i. to maintain an Incident Book not only to record injuries and similar incidents but also complaints by patrons that might be communicated to pool attendants during the day.

I propose to forward the foregoing recommendations and comments to the State Attorney-General for dissemination to the Minister for Local government, the Minister for Sport and Recreation and to any other person or organisation that she deems appropriate.

Case Number 19895082 (State Coroner Johnstone)

I propose to forward my recommendations and comments to the Attorney-General for dissemination to the Minister for Local Government, the Minister for Youth, Sport and Recreation, the Royal Life Sawing Society, Institute of Swimming and Recreation Centre Management, Vic Swim, the Municipal Employees Union, the Local Government Engineers Association, ALEF Security and the Town Clerk of the City of Springvale.

Evidence has been given that swimming under pool covers leads to loss of bearing and obvious lack of the ability to obtain access to oxygen and thereby is extremely dangerous.

This case highlights the need for the introduction of procedures (by way of a Code of Practice) for all public swimming pools relating to:

1. The placing of pool covers on pools and specifically:
    a. avoiding partial covering of pools whilst patrons (especially young children) are present or the pool is open;
    b. the use of public warnings and warning signs in appropriate places;
    c. where the pool is fully covered an appropriate level of supervision or alternatively avoiding covering a pool whilst patrons are in the pool environment.
2. An appropriate level of security fencing, maintenance and security patrols for public swimming pools.

There is a need for all swimming pool management and employees to be aware of the dangers and the need for an adequate level of supervision where pool covers are used.

It may be appropriate for a warning to be included in the Newsletter for the Institute of Centre Recreation Management and the Findings to be forwarded to independent industry groups such as the Swimming Pool and Spa Association.

It is also noted there has been a previous death in January 1989 involving drowning in a public swimming pool under a pool cover. See 0472/1989.

Case Number 19890472 (Coroner Hill)

I recommend that the City of Fitzroy take all reasonably necessary steps to secure the pool from wrongful entry particularly by replacing the cyclone fence with a more secure barrier.