IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 006361

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	Master K
Date of birth:	[redacted] 2019
Date of death:	27 November 2021
Cause of death:	1(a) Drowning
Place of death:	Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria
Key words:	*Drowning, child, pool, supervision*

INTRODUCTION

1. On 27 November 2021, Master K was two years old when he died in hospital after being found unresponsive in a pool.

2. At the time of his death, Master K lived in [redacted] with his parents and siblings.

THE CORONIAL INVESTIGATION

3. Master K's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. Victoria Police assigned Detective Senior Constable Mallory Bubb to be the Coroner's Investigator for the investigation of Master K's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. In addition, I asked the Coroners Prevention Unit (**CPU**)[1] to compile data on drownings of young children where the lack of supervision was a possible factor in the fatal incident.

8. This finding draws on the totality of the coronial investigation into Master K's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative

[1] The CPU was established in 2008 to strengthen the coroner's prevention role and to assist in formulating recommendations following a death. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health. The CPU may also review the medical care and treatment in cases referred by the coroner as well as assist with research into public health and safety.

clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

Background

9. Master K was the youngest child of Ms L and Mr K. His older siblings were Master R (seven years old) and Master D (three years old).

10. In 2016, Ms L, Mr K, and Master R moved from [redacted] to Australia. Master D and Master K were born thereafter.

11. Mr K described Master K as a smart and talkative child who adored his brothers. He also loved to eat, especially fruit, and loved music; he used to intuitively break into a dance whenever he heard a melody.

12. Master K was described as a healthy child with no known medical conditions.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

13. On 19 November 2021, the family arrived at Crown Towers in Melbourne for what was described as a family 'staycation'. Also with the family were Ms L's younger sister, Miss P (13 years old), and Ms L's nephew, Master O (12 months old).

14. The family's check-in into the hotel was initially delayed due to Mr K having to download proof of his COVID-19 vaccination certificate to his mobile phone. According to Ms L and Mr K, they were both stressed while this was worked out.

15. The family subsequently entered their hotel room at 8.39pm.

16. At about 9.11pm, Ms L took her three children, her sister, and nephew to the pool on Level 3 of the hotel. The spa reception, which leads to the pool hall, and the pool hall are both covered by closed-circuit television (**CCTV**) cameras which captured that evening's events in their entirety.

[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

17. According to Detective Senior Constable Bubb, the pool hall on Level 3 comprises a large open pool, including a shallow 'toddler pool' section which joins to a deeper 'adult pool' section. The toddler pool and the adult pool are separated by four large flat square landings which are between 1.5 metres and 2 metres square. These sections serve to act as a semi-barrier between the toddler pool and the adult pool and likely an area where people can sit by the pool edge. In between each square landing is a small gap which is wide enough for a child to pass through. Beyond these square landings are three large steps which progress deeper into the adult pool, which is 1.2 metres deep.

18. Detective Senior Constable Bubb noted that the pool hall is not staffed by a lifeguard. This information is conveyed to patrons throughout the spa reception and the pool hall as follows:

> *Unsupervised aquatic environment, no lifeguard on duty. Children under the age of 16 must be supervised by an adult in the pool area*

19. These signs are located next to the spa reception desk and are embossed onto the glass doors leading into the pool hall.

20. When she arrived at the spa reception, Ms L entered details into the sign-in book. A notice in the book provides patrons with the pool's conditions of use including:

> *Children under 5 years of age must be accompanied into the water and remain within arm's reach at all times*

21. While Ms L completed the sign-in book details and purchased swim nappies at the spa reception, Miss P walked with the children into the pool hall toward the lounge chairs at the west end.

22. At about 9.15pm, Ms L joined the children in the pool hall. Shortly thereafter, Master K entered the toddler pool with the assistance of his mother.

23. For the following 10 minutes or so, Ms L sat on a nearby lounge filming videos of the children on her mobile phone while Master K played in the water in the toddler pool. A video recorded on Ms L's mobile phone and submitted as part of the coronial brief captured Master K and Master D playing in the toddler pool, with Miss P holding Master O in the adult pool.

24. At about 9.22pm, Ms L entered the toddler pool. A two-part video of 15 seconds and nine seconds recorded on Ms L's mobile phone, time stamped at 9.23pm, captured Master K and Master D playing in the toddler pool, with Miss P and Master R in the adult pool.

25. At this time, two other adult patrons, Mr and Mrs E were seated on pool lounge chairs to the west of Ms L, watching their two children swimming.

26. At 9.25pm, a Crown pool attendant approached Ms L, who was still sitting in the toddler pool, and informed her the pool would be closely shortly.

27. Over the following several minutes, Ms L made video calls while holding Master O in the toddler pool. At this time, CCTV footage captured Master K and the other children playing in the toddler pool, climbing on, and walking in between the square landings and walking along the first step leading into the adult pool.

28. A 13 second video recorded on Ms L's mobile phone, time stamped at 9.33pm, captured Ms L holding Master O in her lap, splashing him with water in the toddler pool. This is captured on CCTV footage at about 9.31pm.

29. Call records of Ms L's mobile phone indicate that she spoke to her husband for 17 seconds at 9.32pm. CCTV footage captured Ms L answer this phone call, holding the phone to her ear.

30. At 9.33pm, CCTV footage captured Master K walking on the first step leading into the adult pool. At this time, Ms L was positioned about two metres away using her mobile phone and looking down at the screen.

31. CCTV footage subsequently captured Master K losing his balance from the first step and falling forward into the adult pool. For the next two minutes and 23 seconds, Master K thrashed around on his back under water. He then stopped struggling and rolled onto his front. He thereafter remained floating face down just below the water's surface of the adult pool.

32. It is evident that Ms L did not observe this event. CCTV footage shows that she remained in the toddler pool at this time, looking down at her mobile phone.

33. No other pool patrons observed the event either. For the next seven minutes, no one in the pool hall observed Master K floating unresponsive in the pool.

34. At 9.37pm, Mr K entered the pool hall and walked over to his wife who was still sitting in the toddler pool, holding Master O and using her mobile phone. Mr K took some photos of Ms L and Master O with his own phone at this time.

35. At 9.40pm, Mr K entered the adult pool. Shortly thereafter, Ms L also entered the adult pool holding Master O.

36. At 9.43pm, other adult patrons noticed Master K floating in the water. Mr E immediately jumped into the water, retrieving Master K who was unresponsive. By this time, Master K had been in the adult pool unnoticed for nine minutes and 24 seconds.

37. Master K was taken to a lounge chair. Mr K began administering cardiopulmonary resuscitation (**CPR**). Other pool patrons and Crown security officers then took over and continued to provide CPR.

38. At 9.49pm, Crown first aid officers arrived. Master K was moved to the floor where CPR continued. A defibrillator was applied, which analysed Master K approximately five times, each time showing he had in asystole with no shock advised.

39. At 9.58pm, Victoria Police members and Fire Rescue Victoria (**FRV**) members arrived. FRV members took over CPR.

40. At 10.03pm, Ambulance Victoria paramedics arrived and continued CPR. Master K was subsequently intubated and transferred to the Royal Children's Hospital at 10.39pm.

41. In hospital, investigations revealed Master K had suffered diffuse brain oedema consistent with a severe hypoxic insult related to submersion in water and drowning.

42. Over the following days, there was no change in Master K's condition. On 21 November 2021, tests confirmed brain death.

43. Master K remained on a ventilator until his heart ceased beating at 1.30pm on 27 November 2021.

Identity of the deceased

44. On 27 November 2021, Master K, born [redacted] 2019, was visually identified by his father, Mr K.

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

Medical cause of death

46. Forensic Pathologist, Dr Paul Bedford, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 29 November 2021 and provided a written

report of his findings dated 20 December 2021. He provided a supplementary report on 7 September 2023.

47. The post-mortem examination was consistent with the reported circumstances.

48. Toxicological analysis of ante-mortem samples collected on 20 November 2021 identified the presence of morphine,[3] midazolam,[4] levetiracetam,[5] and metoclopramide.[6]

49. Dr Bedford provided an opinion that the medical cause of death was *"1(a) Drowning"*.

50. In his supplementary report, Dr Bedford noted that drowning in infants and toddlers can occur from as low a time period as 20 seconds.

51. He noted that the CCTV footage showed that Master K was seen to struggle on his back for two minutes 23 seconds before succumbing and rolling on to his front. Dr Bedford was of the opinion that while Master K was struggling there was water in Master K's airways and there had been some degree of lack of oxygen to the body. Therefore, once he became unconscious, brain death may have already occurred or would have occurred in the next minute or so.

52. I accept Dr Bedford's opinion as to the matters described above.

FURTHER INVESTIGATION

Coroners Prevention Unit review

53. As part of my investigation, I requested the CPU to compile data on drownings of young children where a lack of supervision was a possible contributing factor to the fatal incident.

54. For the purposes of this task, 'young child' was defined as any child aged up to four years of age and the search was restricted to unintentional drowning deaths of young children that occurred between 1 January 2010 and 31 March 2024.

55. The CPU identified that for the period between 1 January 2010 and 31 March 2024, there were 47 drowning deaths of children aged between newborn to four years of age.

56. Table 1 below demonstrates the annual number of deaths for this period by child age in years.

[3] Morphine is a narcotic analgesic used for the treatment of moderate to severe pain.
[4] Midazolam is used as a preoperative medication, antiepileptic, sedative-hypnotic, and anaesthetic induction agent.
[5] Levetiracetam is an antiepileptic used for the control of partial onset seizures.
[6] Metoclopramide is an anti-emetic drug used for the treatment of nausea and vomiting.

57. Children aged one year represented the highest age group of drownings, followed by those aged two years. The CPU noted that children at this age become more mobile, and they are curious and unpredictable.

58. The CPU also postulated that the seven and five deaths in 2020 and 2021 (respectively) could possibly be linked to the COVID-19 pandemic where people were at home more, parents had competing priorities, and there was a lack of swimming lessons familiarising children to water. This trend has not continued.

	Age (years)					
Year	0	1	2	3	4	Total
2010	1	4	1	-	-	6
2011	-	-	-	-	-	-
2012	1	2	-	-	1	4
2013	-	2	2	-	-	4
2014	1	1	-	1	2	5
2015	1	1	1	-	-	3
2016	-	1	1	1	-	3
2017	1	-	1	1	-	3
2018	-	1	-	2	-	3
2019	-	-	-	-	-	-
2020	2	1	3	-	1	7
2021	-	1	2	1	1	5
2022	-	2	-	-	-	2
2023	1	-	-	1	-	2
2024*	-	-	-	-	-	-
Total	8	16	11	7	5	47

Table 1: Annual number of unintentional drowning deaths among young children, Victoria 2010-2024 (*2024 data is part-year to 31 March)

59. Among the 47 deaths, the available evidence suggested inadequate supervision was a factor in 43 deaths. Only one death (other than Master K) occurred in a public pool.

60. In 11 of the 47 deaths, coroners made comments about child supervision around water which were largely consistent. I highlight the following broad themes as follows:

(a) bodies of water are a temptation to young children because they represent a fun activity and adventure;

(b) however, children do not adequately understand the dangers of water;

(c) parents therefore need to be vigilant and exercise adequate supervision of children in and around bodies of water;

(d) a brief lapse of vigilance can have tragic consequences;

(e) children can drown in as little as 20 seconds without making any noise;

(f) children can drown in shallow water (only a few centimetres deep);

(g) use of life vests or other buoyancy aids are not a substitute for close, focussed, and active supervision; and

(h) adults should not assume someone else is supervising the child.

COMMENTS

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

61. I note that in this case the Office of Public Prosecutions advised Victoria Police that charges for Child Homicide in circumstances of Criminal Negligence should not proceed in the circumstances.

62. The available evidence, including CCTV footage from Crown, suggests that Master K was not adequately supervised by his mother whilst in the pool in the time proximate to his death, and that her mobile phone and the care of at least one other child appears to have been a significant distraction. At the time of Master K's drowning, his mother was no more than a couple of metres away.

63. Master K's tragic death and the circumstances of his drowning highlight the need for close supervision of young children, especially in and around pools.

64. This is a safety message that is consistently repeated by a number of child and water related authorities. The Royal Children's Hospital,[7] Kidsafe,[8] Life Saving Victoria,[9] and the Victorian Government[10] all provide the following similar advice:

(a) supervision means constant visual contact, not the occasional glance;

[7] Royal Children's Hospital, Safety: In and around water, see https://www.rch.org.au/kidsinfo/fact_sheets/water_safety/.
[8] Kidsafe, Water Safety, see https://www.kidsafevic.com.au/water-safety/.
[9] Life Saving Victoria, Water Safety Information, see https://lsv.com.au/diversityinclusion/water-safety-information/.
[10] Victoria Government, Water Safety, see https://www.vic.gov.au/water-safety.

(b) adults should actively supervise children, even if the child can swim;

(c) supervising adults should avoid all distractions, including using a phone or answering the door;

(d) do not leave older children (under the age of 16 years) to supervise younger siblings; and

(e) children under five years must be within arms' reach, and children under 10 years must be clearly and constantly visible and directly accessible.

65. Acknowledging the effect this tragic event has had on Master K's family and the wider community, I echo and support the comments made by Coroner David Ryan in his Finding into Death Without Inquest regarding KW as follows:[11]

> *These findings and comments are not made by way of criticism of KW's parents who have suffered a devastating tragedy. They are deserving of sympathy and not judgment. The comments are provided as a salutary warning to all caregivers of children so that drowning deaths relating to inadequate supervision can be prevented in the future. The importance of ensuring the safety of children around water cannot be overstated and it should be discussed and planned by caregivers beforehand. It is timely to reiterate and emphasise this message now with another summer having just begun, and much of the Victorian community having recently emerged from lockdowns imposed to manage of the Covid-19 pandemic. As a result, many children will be enthusiastically embracing the opportunity to engage in water-based activities with friends and family, in circumstances where few of those children would have had the opportunity over the last couple of years to develop and improve their swimming skills with organised lessons.*

FINDINGS AND CONCLUSION

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

(a) the identity of the deceased was Master K, born [redacted] 2019;

(b) the death occurred on 27 November 2021 at Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria, from drowning; and

[11] COR 2020 006780, dated 17 December 2021.

(c) the death occurred in the circumstances described above.

I convey my sincere condolences to Master K's family for their loss and acknowledge the profound grief caused by the passing of such a young child.

I commend the efforts of the pool patrons and Crown staff on 19 November 2021 and acknowledge the distress they have experienced as a consequence of this tragic event.

Pursuant to section 73(1A) of the Act, I order that a de-identified version of this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Ms L and Mr K, senior next of kin
Royal Children's Hospital
Ambulance Victoria
Crown Melbourne Ltd (care of Sparke Helmore Lawyers)
Commission for Children and Young People
Kidsafe Victoria
Life Saving Victoria
Detective Senior Constable Mallory Bubb, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 12 November 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.