IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2022 006852

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	BK
Date of birth:	24 December 2020
Date of death:	29 November 2022
Cause of death:	1(a) Circumstances consistent with drowning
Place of death:	[redacted] Victoria

INTRODUCTION

1. On 29 November 2022, BK was 23 months old when he fatally drowned in a fishpond in his grandmother's backyard. At the time, BK lived in [redacted] with his parents and siblings.

2. BK's father, DK, migrated to Australia in 2004. He married MK in 2020 and they went on to welcome three children – GK, HK, and BK.

3. According to Mr DK, BK was a healthy little boy with no known medical issues.

4. In 2018, Mr DK built a small fishpond in the backyard to remind him of his childhood. He noted, *"The pond has fence around and I placed trees pot around the fence as well".*

5. BK had started walking by the time of the incident. Mr DK noted that BK had never ventured into the backyard by himself before as the rear sliding door was always locked. He was always accompanied into the backyard by an adult.

6. According to Constable Patrick Sievers, Coroner's Investigator, the fishpond was located at the backyard of the property against timber fencing. It was not fenced off or enclosed in any way. The fishpond measured 8 feet and 2 inches in length (about 248.9 centimetres), 7 feet and 4 inches in width (223.5 centimetres). It was 2 foot and 2 inches deep (about 60.9 centimetres). The pond had a rocky, uneven bottom and was constructed from timber, lined with black plastic, and filled with rocks. The pond was surround by pot plants.

THE CORONIAL INVESTIGATION

7. BK'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.

8. 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.

9. 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.

10. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of BK'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.

11. This finding draws on the totality of the coronial investigation into BK'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 clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Identity of the deceased

12. On 29 November 2022, BK, born 24 December 2020, was visually identified by father, DK, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

14. Forensic Pathologist, Dr Sarah Parsons, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 1 December 2022 and provided a written report of her findings dated 7 December 2022.

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

16. Routine toxicological analysis of post-mortem samples did not detect any alcohol or any commonly encountered drugs or poisons.

17. Dr Parsons provided an opinion that the medical cause of death was *"1(a) Circumstances consistent with drowning"*.

[1] 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.

18. I accept Dr Parsons's opinion.

Circumstances in which the death occurred

19. On 29 November 2022, Mr DK and Ms MK went to work while GK and HK attended school. BK remained at home with his grandmother, EK.

20. According to the Victoria Police *Report of Death for the Coroner* (VP Form 83) completed by Constable Sievers, Ms EK was in the shower from about 11.50am until 12.20pm. Despite Constable Sievers's efforts, a statement has not been obtained from Ms EK. However, the evidence reveals the following sequence of events.

21. At approximately 12.20pm, Ms EK entered the backyard and found BK face down and unresponsive in the fishpond.

22. AP who lived next door, heard Ms EK screaming in the backyard. He yelled out to her, looked over the fence and observed Ms EK holding BK unresponsive in her arms.

23. Ms EK ran over to Mr AP's house where emergency services were contacted. Mr AP commenced administering cardiopulmonary resuscitation (**CPR**) as directed by the emergency services call-taker.

24. Ambulance Victoria paramedics and Fire Rescue Victoria members arrived a short time later and took over CPR efforts. Paramedics subsequently verified BK's death at 1.32pm.

25. It appears the rear sliding door had been inadvertently left unlocked, which allowed BK to open the door himself to access the fishpond.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was BK, born 24 December 2020;

    (b) the death occurred on 29 November 2022 at [redacted] Victoria;

    (c) the cause of BK's death was circumstances consistent with drowning; and

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

27. BK's family were too distressed to participate fully in the coronial investigation by providing statements for the coronial brief, but they did provide information on an informal basis to court staff, and I thank them for that. I also wish to convey to my deepest condolences for the loss of BK to all his family and friends.

COMMENTS

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

28. According to the Victorian Building Authority (**VBA**), ornamental ponds and water features do not require a building permit and they have different requirements to swimming pools and spas which require a safety barrier and building permit.

29. The VBA requires compliant safety barriers for all swimming pools and spas capable of containing water to a depth greater than 30 centimetres. This includes above-ground pools and spas, including relocatable and inflatable pools and bathing and wading pools capable of holding more than 30 centimetres of depth of water.[2]

30. Fishponds do not require a barrier. The VBA, however, warns that *"any structure containing water may pose a risk of drowning – even if a safety barrier is not legally required"*.[3]

31. The Coroners Prevention Unit[4] (**CPU**) has previously identified 47 drowning deaths of children aged between newborn to four years of age during the period 1 January 2010 and 31 March 2024. Table 1 below demonstrates the annual number of drowning deaths for the period 2010 to 2024 by child age in years.

[2] Victorian Building Authority, Pool safety barriers, https://www.vba.vic.gov.au/consumers/swimming-pools/pool-safety-barriers, accessed 17 September 2024.
[3] Victorian Building Authority, Landscaping, https://www.vba.vic.gov.au/consumers/home-renovation-essentials/landscaping, accessed 17 September 2024.
[4] 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.

Year	Age (years) 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)

32. 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 or toddlers become more mobile and are curious about their environment and unpredictable.

33. This is recognised by the Australian Water Safety Strategy 2030:[5]

> *Toddlers are curious and increasingly mobile but lack an understanding of water-related hazards, making them vulnerable to drowning in and around the home, particularly in private swimming pools and dams on rural properties. Parental and carer supervision is considered critical to preventing drowning, so educating each new generation is a high priority.*

34. For the purposes of this investigation, I asked the CPU to compile updated statistics, specifically about the drowning deaths of young children in water bodies such as ponds and dams on residential properties.

[5] Australian Water Safety Council, *Australian Water Safety Strategy 2030*, Sydney: Australian Water Safety Council, 2021, p.16.

35. The CPU subsequently identified 12 drowning deaths of children aged between 0-4 years where the location was a residential water body during the period 1 January 2010 and 31 August 2024. The deaths comprised:

(a) five drowning deaths in private dams;

(b) four drowning deaths (including that of BK) in a fishpond or pond;

(c) two drowning deaths in buckets; and

(d) one drowning death in a septic tank.

36. The Royal Life Saving Society Australia's safety and supervision messaging for young children emphasises backyard pools and spas, and the importance of fencing pool areas. However, they also provide more general advice as follows:[6]

> *Buckets, bathtubs, eskies (coolers), water fountains and features, fishponds, drains, inflatable pools, water tanks and even pet bowls all pose a significant drowning risk especially to younger children. It is crucial that these are emptied, covered, put away and not left where they can fill up with water. Inflatable pools should be emptied after use and stored securely out of reach of children.*
>
> *Most toddler drowning deaths occur when parents' attention is divided. Everyday household tasks such as attending to other siblings, preparing meals, answering the front door and phone calls are just a few of the many distractions that can interfere with supervision.*

37. Victorian coroners have previously made largely consistent comments about child supervision around water which highlight the following broad themes:[7]

(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 posed by bodies of water;

[6] Royal Life Saving Society Australia, Water safety at home, https://www royallifesaving.com.au/stay-safe-active/locations/water-safety-at-home, accessed 20 September 2024.
[7] Emphasis is my own.

(c) carers 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.

38. The Australian Water Safety Strategy 2030 includes activities to support messaging about the importance of active adult supervision, such as:[8]

> *Coordinate child drowning campaigns targeting the importance of active supervision at all times around water and barriers to prevent children accessing water unaccompanied.*

39. Given a child can drown in only a few centimetres of water, it is noteworthy that the VBA does not require safety barriers for fishponds. Fishponds are undoubtedly attractive to a young child, and it is entirely conceivable that they would be located in a child's own backyard at a depth greater than 30 centimetres.

40. Given the considerable risk to young children posed by fishponds, I direct that this finding be provided to the to the VBA for their consideration of the need to regulate the building and design of fishponds in the interest of child safety.

41. I also note that BK is one of 12 children aged 0-4 years who have drowned in bodies of water such as dams, ponds and fishponds in residential settings in Victoria since 2010. Four of these deaths occurred in a backyard fishpond. A common factor across many of the fatal incidents was inadequate adult supervision.

[8] Australian Water Safety Council, *Australian Water Safety Strategy 2030*, Sydney: Australian Water Safety Council, 2021, p.17.

42. It is imperative, especially in the lead up to the next summer season, that the Victorian community continue to be reminded that young children are risk of unintentional drowning in young children in all types of bodies of water.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

MK and DK senior next of kin

Victorian Building Authority

Life Saving Victoria

The Commission for Children and Young People

Constable Patrick Sievers, Victoria Police, Coroner's Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 24 September 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.