IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 001485

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	Nihal Singh Hundal
Date of birth:	29 November 2019
Date of death:	19 March 2023
Cause of death:	1(a) Drowning
Place of death:	Wallan, Victoria[1]
Key words:	*Drowning*; *child*; *septic tank*

[1] At the request of the family, the place of death has been de-identified.

INTRODUCTION

1. On 19 March 2023, Nihal Singh Hundal was three years old when he tragically drowned in a septic tank on a friend's property.

2. At the time of his death, Nihal lived in Wollert with his parents, Parambir Singh Hundal and Amanpreet Kaur, and his younger sister, Meher.

THE CORONIAL INVESTIGATION

3. Nihal'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 Leading Senior Constable Craig Nieman to be the Coroner's Investigator for the investigation of Nihal'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**)[2] to compile statistics of similar deaths and advise me about the safety requirements of septic tanks.

8. This finding draws on the totality of the coronial investigation into Nihal's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only

[2] 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.

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.[3]

Background

9. Amanpreet moved to Australia in 2008. In 2016, she returned to India to marry Parambir and they both settled in Australia. The couple welcomed Nihal in November 2019. Meher was born just under three years later.

10. Nihal did not have any known medical conditions and was described as a perfectly healthy child. Toward the end of 2022, Nihal began attending speech therapy. He spoke both Punjabi and English and loved attending swimming lessons.

11. The family are Sikhs and worshipped with their community on Sundays at the Craigieburn temple.

12. On Saturday 18 March 2023, Nihal attended the Colour Festival at the Community Centre in Mernda. Amanpreet recalled that Nihal had loved the festival, he had been covered with multiple colours and was delighted when he was allowed to keep the water gun he had been playing with that day.

13. That evening, Nihal ate chicken nuggets while his parents and their houseguest ate pizza. He was allowed to drink some Coca Cola as a reward for cleaning up his toys earlier. As he had not had a nap that day, Parambir took Nihal for a drive so he would fall asleep.

14. Once he had fallen asleep, Parambir returned and carried his son to bed. Nihal slept through the night.

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

Circumstances in which the death occurred

15. On the morning of Sunday 19 March 2023, Nihal woke and wished his mother a Sikh greeting in the bathroom. While his mother usually greeted him in this way, Nihal had never said it before. Amanpreet recalled she was very proud of him.

[3] 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.

16. Parambir said that Nihal had sat on his chest in bed and said a morning prayer.

17. Nihal had breakfast, eating half of his two Weet-Bix with warm milk. Amanpreet then dressed her son, tying his long hair in a bun and putting his turban on.

18. The family then made their way to Wallan where they attended a housewarming prayer function.

19. When they arrived at about 12.05pm, Nihal was excited to see chickens on the property and other children playing and ran from his parents. He returned to Amanpreet when she called him, and they went into the house.

20. Following prayer, Amanpreet and Nihal went out to the backyard where food was provided for guests in a shed. They later returned to the house so Nihal could get a prashad, which was a treat given out after prayer.

21. Over the following hour or so, Nihal enjoyed playing with the other children and seeing the chickens. At one point, the adults were alerted to children playing near the pool. Amanpreet subsequently found Nihal standing outside of the pool fence, but Nihal's right sleeve and right pant leg was wet. The pool fence gate was then locked.

22. Amanpreet tried to change Nihal's wet clothes, but he did not want to. As it was a warm and sunny day, his parents let his clothes dry while he played.

23. At about this time, Amanpreet's aunt, Gurpreet Toor, carried Meher over to her mother as she was crying and hungry. Intending to take Meher into the house for a feed, she said to Nihal, *"Come inside, let's go".* But Nihal did not want to go inside.

24. So, Amanpreet decided to leave Nihal in the front yard near the side gate to play; she shut the gate so Nihal could not go back to the pool area. Amanpreet later told police that she was not concerned about Nihal playing in this area as he had been playing in that area for most of the day. There was also another woman, Swaran Kaur, who was sitting on a chair outside the front door facing the septic tank, small hill, and chickens.

25. Amanpreet took Meher inside for a feed. Gurpeet subsequently joined her for a short period before going outside again. As she left, Amanpreet asked her to check on Nihal. Gurpeet nodded.

26. When she went outside, Gurpeet spoke to Swaran and then walked to the backyard to ask a relative to assist Swaran to walk to the shed for lunch. Gurpeeet subsequently remained in the shed.

27. After feeding Meher, Amanpreet went out to the front yard. Not seeing Nihal, she made her way to the backyard to look for him, but he was not there. She continued looking for Nihal, making her way back up the driveway to the front yard, and around the chicken coop, pond, and inside the house. She grew increasingly concerned.

28. At 1.33pm, Amanpreet called a family to member to see if Nihal was in the backyard, but he was not there. At this point, other family members began looking for Nihal around the property, later joined by the other guests. None of the children had seen Nihal.

29. At about 1.48pm, a child running in the front yard stepped on the septic tank, which flipped the tank's lid. The child partially fell into the tank. Amanpreet and another guest ran to the child at which point Amanpreet saw Nihal's jumper inside the septic tank. She began yelling, believing it was only the jumper in the tank. Other guests ran over at which time they realised Nihal was floating face down in the septic tank.

30. Nihal was pulled from the tank in an unresponsive state. Guests began administering cardiopulmonary resuscitation (**CPR**) whilst emergency services were called.

31. Ambulance Victoria paramedics arrived at the scene at 2.00pm, finding Nihal with no pulse and not breathing. A defibrillator was applied but no shock was administered. CPR continued with multiple doses of adrenaline administered. At 2.51 and 2.55pm, a faint carotid pulse was detected, and he was defibrillated on these occasions with no sustained results. Resuscitative efforts continued until 3.02pm when Nihal was sadly verified deceased.

32. Attending Victoria Police members examined the septic tank and lid. Detective Leading Senior Constable Craig Nieman, Coroner's Investigator, described the tank opening as grey plastic pipe that was approximately eight centimetres (**cms**) above ground. The pipe appeared to be a corrugated shape with space at the top of the pipe for the lid to fit into and sit on top of the pipe. The lid was made of black plastic and was a circular shape. The lid had six small holes at equal distances around the outer edge of the lid. It appeared that the holes were there to enable it to be fixed to the pipe with screws. However, no screws were found and there were no holes located in the pipe where the lid had been sitting. The pipe appeared to be between 60 and 70 cms wide. The lid did not fit snugly into the pipe opening and had space to move about. The lid was light and was easily moved.

33. Police measured the depth of the tank as 1.22 metres from the surface of the sludge/fluid in the tank to the bottom of the septic tank. The distance from the top of the tank opening to the surface of the sludge/fluid was 60 cms.

34. Detective Leading Senior Constable Nieman concluded that Nihal had been playing in the area in front of the house in the vicinity of the septic tank. He likely stepped onto the loose lid, which caused it to dislodge, allowing Nihal to fall into the septic tank. He was unable to climb out of the tank and tragically drowned.

35. Amanpreet later stated to police that she had been told a child had found the septic lid half open and had pushed it closed with his foot.

36. The owner of the property stated to police that he and his family had moved into the property in December 2022. He was informed of the two septic tanks on the property and was told they needed to be cleaned every three years. He was unaware the lid could be moved as he had never touched the septic tank or looked inside it.

37. Following the incident, a plumber secured the lid in place by screwing four to six screws around the lid. In his statement to police, he stated the septic tank had been installed over 20 years ago. The house had been renovated extensively since then and it appeared that the tank had either been lowered or the ground level raised, which required an extension pipe above the lid. He noted the extension/raising pipe had been installed over the access hole and the original lid had been placed on top. There was no fastening and the light plastic lid had been sitting loosely on top of the pipe. He had to trim the outside of the lid to enable the lid to fit inside the extension pipe and back in its original position on top of the tank.

38. Detective Leading Senior Constable Nieman later spoke to Adam Evans, Mitchell Shire Community Amenity who advised as follows:

> *It is the requirement of the owner of the property to ensure that the septic system is in working order. This includes regular servicing and inspections by a qualified plumber. There are no requirements for safety screens/nets to be installed. Council does provide education to property owners with septic systems. Council does conduct proactive inspections of septic systems, the noted system has not received a proactive inspection.*
> *…*

We have reviewed all paper records associated with the property and Council has no record of a septic system on the land. Unfortunately, due to amalgamation there are a number of issues finding old paper records.

Identity of the deceased

39. On 19 March 2023, Nihal Singh Hundal, born 29 November 2019, was visually identified by his uncle, Roop Kamala Jaur Dadwal.

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

Medical cause of death

41. Forensic Pathologist, Dr Hans de Boer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 21 March 2023 and provided a written report of his findings dated 5 June 2023.

42. The post-mortem examination did not identify relevant positive findings. As such, the external examination was consistent with the provided history. There was no post-mortem evidence of substantial injury.

43. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

44. Dr de Boer noted that the circumstances strongly suggested drowning as cause or contribution to death. There are no post-mortem findings specific for drowning, and drowning may be entirely without external findings. As such, drowning is a diagnosis of exclusion, which is heavily reliant on the circumstances of a case.

45. Dr de Boer provided an opinion that the medical cause of death was *"1(a) Drowning".*

46. I accept Dr de Boer's opinion.

FURTHER INVESTIGATION

47. As part of my investigation, I asked the CPU to compile statistics of similar deaths and advise me about the safety requirements of septic tanks.

Statistics of similar deaths

48. The CPU searched Coroners Court of Victoria surveillance database and the National Coronial Information System (**NCIS**).[4] The surveillance database contains information on all Victorian deaths reported to the coroner since 1 January 2000. The NCIS includes data on all deaths reported to a coroner in Australia since 1 July 2000.

49. The CPU searched for deaths reported to an Australian coroner between 1 January 2013 and 31 December 2023, where the evidence indicated the deceased was younger than 18 years old and died because of an interaction with a septic tank.

50. From these searches, the only death identified by CPU was that of Nihal Hundal. No other deaths involving children and septic tanks were found on NCIS nationwide since 2013.

51. However, when searching the Kidsafe Victoria website (see further below), it was noted that there had been two additional toddler deaths in septic pits in Australia over the last 18 months.

52. The CPU searched for these deaths on the internet, and concluded they were likely to be the death of a three-year-old boy who drowned in a septic tank in Koah, Queensland, in January 2022; and a two-year-old who fell into a septic tank in the remote community of Mount Liebig in the Northern Territory in February 2023, who was rushed in to the Women's and Children's Hospital in Adelaide but died five days later.

53. As these deaths did not appear in the nationwide searches CPU conducted, they likely remain open coronial cases at the time of writing. The CPU was thus unable to access any other details regarding these deaths and was unable to provide a more detailed account of their circumstances at the time of writing.

54. It follows that the CPU could not find any evidence of Australian coroners making recommendations involving the safety of children around septic tanks.

Septic tank safety

55. Based on the CPU's research, children drowning in septic tanks is an extremely rare death. There is some obvious concern, however, around the fact that three such deaths occurred in an 18-month period.

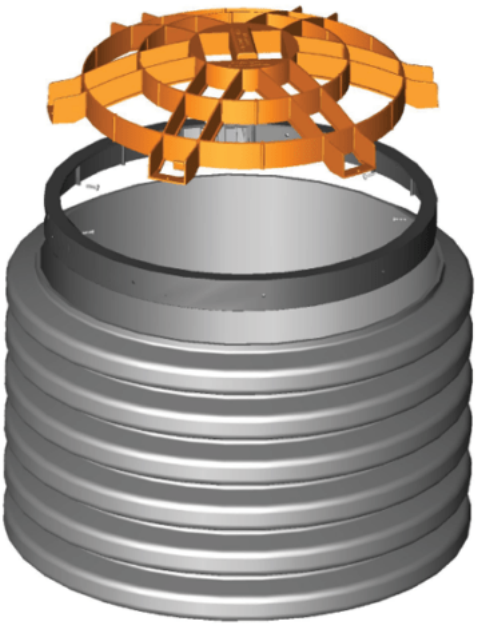
[4] One major limitation was that the NCIS search of Australian deaths was limited only to completed investigations (the CPU does not have NCIS permission to access information about deaths still under investigation) and did not include Western Australian cases (these are not accessible by NCIS users outside Western Australia).

56. The CPU noted that there is a current Kidsafe Victoria campaign named *Nihal's Legacy Program*, which is aimed at *"encouraging all homeowners with septic systems to check the safety of their systems – including making sure that the lid is secure – to help prevent similar incidents"*.[5]

57. Kidsafe Victoria have identified two key priorities to prevent similar deaths as follows:

> *The installation of a child resistant screen under the lid as a secondary backup option if the lid fails – these are not currently available in Australia but we are looking into options*
>
> *A Certificate of Compliance for septic systems when a property is sold or rented – similar to what is required for swimming pools and spas – to help make sure they are in proper working order*

58. The 'child resistant screen' to which Kidsafe Victoria refers is commonly available in the United States and is often referred to colloquially as a 'kid catcher'. It is designed to fit inside the riser of a septic tank (the elevated component which allows access to the tank interior), beneath the septic lid, effectively blocking access to the area. The image below demonstrates the device and where it fits to the septic tank.



[5] Kidsafe, available at: https://www.kidsafevic.com.au/post-injury-support/nihals-legacy-program/, accessed 29 May 2024.

59. Kidsafe Victoria advised that these devices are currently not available in Australia. However, as an inexpensive and presumably easily fabricated device, the CPU did not believe that their importation (or their manufacturing in Australia) would prove difficult to achieve, if required.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Nihal Singh Hundal, born 29 November 2019;

    (b) the death occurred on 19 March 2023 at Wallan, Victoria, from drowning; and

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

COMMENTS

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

61. Whilst the deaths of children in septic tanks are thankfully rare in Australia, I am aware from media coverage that Nihal Hundal was one of three children nationwide who died after falling into a septic tank, in an approximately 18-month period between early 2022 and mid-2023. An opportunity therefore exists to prevent similar deaths in the future.

62. The lid of the septic tank at Wallan, Victoria was not fixed to the pipe with screws, despite there being holes in the lid to facilitate this, did not fit closely on the septic tank's riser pipe, and was light and easily moved. As such, Nihal (despite being a small child) was able to dislodge the lid without intending to do so.

63. Following Nihal's death, his mother worked with Kidsafe Victoria to introduce *Nihal's Legacy Program*, a campaign to raise awareness and advocate for septic pit safety. I commend both Amanpreet and Kidsafe Victoria for attempting to forge something positive from the tragic loss of Nihal. I note that as part of this program, Kidsafe Victoria identified two key priorities to help prevent similar deaths in future. These include the installation of child resistance screens and a Certificate of Compliance.

64. From a prevention perspective, I believe there may be parallels here with the pool safety barrier requirements introduced in Victoria by the Victorian Building Authority after several coronial recommendations were made about preventing access (particularly of children) to domestic swimming pools and spas. If a similar set of requirements were introduced for septic

tanks, this may prevent other child deaths in future. Certainly, the presence of a child resistant screen on the septic tank at Wallan, Victoria may have saved Nihal's young life.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

65. I **recommend** the **Victorian Building Authority** investigate how they might introduce a Certificate of Compliance system for all septic tanks in the state. As part of this investigation, I further **recommend** that the **Victorian Building Authority** consider mandating the installation of child resistant screen devices on all septic tanks in Victoria.

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

Pursuant to section 73(1A) of the Act, I order that this finding be published in a deidentified format 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:

Parambir Singh and Amanpreet Kaur Hundal, senior next of kin
Life Saving Victoria
Victorian Building Authority
Detective Leading Senior Constable Craig Nieman, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 29 May 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.