IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 007095

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	Baby LA
Date of birth:	2023
Date of death:	22 December 2023
Cause of death:	1(a) Hypoxic ischaemic encephalopathy due to an out of hospital cardiac arrest 1(b) Drowning
Place of death:	Monash Medical Centre, 246 Clayton Rod, Clayton, Victoria
Catchwords:	Drowning, child, pond, supervision

INTRODUCTION

1. On 22 December 2023, Baby LA was 10 months old when he died in hospital after being found unresponsive in a fishpond in his backyard.

2. At the time of his death, Baby LA lived in Pakenham with his parents.

THE CORONIAL INVESTIGATION

3. Baby LA's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**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 Rachel Wallace to be the Coroner's Investigator for the investigation of Baby LA'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. This finding draws on the totality of the coronial investigation into Baby LA'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]

[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.

Background

8. Mrs EW and Mr DP married in India in 2017. Mrs EW migrated to Australia that year, initially to study information systems but she later studied nursing. Mr DP joined her in Australia in 2022.

9. Baby LA was their first child. He was born via caesarean section at St John of God Berwick Hospital without complication. He had no medical history and met all age-appropriate developmental milestones. For the first few months of Baby LA's life, his paternal grandparents stayed in Australia to help care for him. They returned to India when he was about six months old.

10. The family lived with Mr DP's sister, Ms YT, and her family, including her husband and two young children. Mrs EW noted that they all lived together as one big family. All the adults cared for the three children as their own.

11. Mrs EW worked afternoon shifts as a nurse at a local medical clinic and Mr DP worked day shifts in a factory.

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

Circumstances in which the death occurred

12. On 15 December 2023, Baby LA was at home in Pakenham. In the morning, he was in the care of his mother.

13. Mr DP finished work and arrived home at about 3.35pm. He thereafter drove Mrs EW to work at 3.45pm for her shift at 4.00pm. Baby LA stayed at home with Ms YT during this time.

14. When he arrived home a short time later, Mr DP played with his son for a while before giving him a bottle. Baby LA then had a nap. Once he was awake, Mr DP played with his son again.

15. At this time, the sliding door to the backyard pergola area was left open and Baby LA was allowed to crawl freely in and out of the house and into the backyard. Mr DP stated that his son always played in the pergola area, and around the house. He was able to crawl around and stand up while holding onto something. He was usually able to see Baby LA from inside the house if he was playing in the backyard.

16. Ms YT cooked dinner in the outdoor kitchen at this time whilst talking on her mobile phone and wearing earphones.

17. The following events were captured on closed-circuit television (**CCTV**) at the house.

18. At 6.40pm, Baby LA crawled towards a small pond from the southern side of the house (rear yard area).

19. At 6.43pm, Baby LA reached the pond and sat on the eastern side of pond. Here, he removed a light and unsecured steel grate covering the pond. He splashed in the water with his hands.

20. At 6.45pm, Baby LA fell into water face first. He immediately rolled onto his back and began struggling.

21. At 6.48pm, CCTV footage captured Baby LA stop struggling and become still in water.

22. For the next 27 minutes, Baby LA remained unobserved and submerged in the water.

23. At 7.12pm, Ms YT observed Baby LA in the water, which was only a few metres from where she had been preparing dinner in the outdoor kitchen. She immediately pulled her nephew from the water and carried him inside.

24. Mr DP then drove Baby LA to the local medical centre at which Mrs EW worked. Here, Baby LA received first aid from one of the resident doctors and emergency services were contacted.

25. Ambulance Victoria paramedics arrived at 7.27pm, finding Baby LA in cardiac arrest. Resuscitation was prolonged, requiring intubation and multiple doses of adrenaline, followed by an adrenaline infusion. Return of circulation took approximately 40 minutes.

26. Baby LA was then transferred to Monash Children's Hospital via helicopter at 9.28pm.

27. At hospital, Baby LA was admitted to Paediatric Intensive Care Unit (**PICU**) where he was managed with neuroprotection for 72 hours. His admission was complicated by a brief period of witnessed loss of output, requiring cardiopulmonary resuscitation, likely secondary to a right-sided pneumothorax as evident on the chest x-ray. A right chest drain was inserted by the PICU medical team on 16 December 2023 with subsequent improvement in his ventilation. He grew Acinetobacter calcoaceticus-baumannii complex and Staphylococcus aureus in his sputum and was treated with antibiotics, although he never developed a pneumonia with respiratory compromise.

28. After the period of neuroprotection when the sedation was weaned, Baby LA's neurology remained poor with no response to painful stimuli centrally or peripherally and persistently sluggish pupils.

29. An MRI brain was done on 19 December 2023, which showed severe hypoxic brain injury.

30. Multiple family meetings were conducted by the PICU medical team and the family were informed of the finding of severe hypoxic brain injury with no chance of recovery.

31. Baby LA was transitioned to end of life care and extubated on the afternoon of 21 December 2023. He passed away at 10.58am on 22 December 2023 surrounded by his family.

32. Victoria Police members attended Baby LA's home. They noted that there was an inground pond measuring approximately 1200mm long and 800mm wide and 200mm deep along the left side of the house. A wire grate had been removed, which exposed part of the pond. This pond was adjacent to a patio area which had a sliding door to access the lounge area of the house. An inflatable pool containing water was also in the backyard.

33. The CCTV footage revealed that Ms YT was approximately seven metres away from Baby LA but she did not notice him in the pond until 7.12pm. Mr DP was not in the backyard at the time of the incident.

Identity of the deceased

34. On 22 December 2023, Baby LA, born in 2023, was visually identified by his uncle.

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

Medical cause of death

36. Forensic Pathologist, Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 22 December 2023 and provided a written report of her findings dated 24 January 2024.

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

38. Dr Archer provided an opinion that the medical cause of death was *"1(a) Hypoxic ischaemic encephalopathy due to an out of hospital cardiac arrest"* secondary to *"1(b) Drowning".*

39. I accept Dr Archer's opinion.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Baby LA, born in 2023;

    (b) the death occurred on 22 December 2023 at Monash Medical Centre, 246 Clayton Rod, Clayton, Victoria, from hypoxic ischaemic encephalopathy due to an out of hospital cardiac arrest secondary to 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.

Requirements for backyard ponds

41. I note Deputy State Coroner Paresa Spanos set out Victorian building requirements for fishponds in her finding into the death of BK, which also concerned the fatal drowning of a child who was playing unsupervised near a fishpond in his backyard.[2]

42. In that finding, her Honour noted that the Victorian Building Authority (**VBA**) does not require a building permit for ornamental ponds and water features – which is different to the requirements for safety barriers and building permits for swimming pools and spas.

43. 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.[3]

44. Fishponds, however, do not require a barrier. The VBA warns that *"any structure containing water may pose a risk of drowning – even if a safety barrier is not legally required"*.[4]

[2] Finding into Death Without Inquest regarding BK, COR 2022 006852, published 24 September 2024.
[3] Victorian Building Authority, Pool safety barriers, https://www.vba.vic.gov.au/consumers/swimming-pools/pool-safety-barriers, accessed 17 September 2024.
[4] Victorian Building Authority, Landscaping, https://www.vba.vic.gov.au/consumers/home-renovation-essentials/landscaping, accessed 17 September 2024.

45. In her Finding, Deputy State Coroner Spanos noted that fishponds are undoubtedly attractive to a young child and 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.

46. In recognition of the risk to young children posed by fishponds, her Honour directed that her finding be provided to the VBA for their consideration of the need to regulate the building and design of fishponds to promote child safety.

47. In the interests of providing further material to inform their consideration, I will also distribute my finding to the VBA.

Statistics for similar fatal drownings

48. In my investigation of another child drowning, I requested the Coroners Prevention Unit[5] (**CPU**) compile a report regarding fatal drownings amongst young children.[6]

49. The CPU identified 47 drowning deaths of children aged between newborn to four years of age during the period 1 January 2010 and 31 March 2024.

[5] 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.
[6] Finding into Death Without Inquest regarding Master K, COR 2021 006361, published 11 November 2024.

50. Table 1 below demonstrates the annual number of drowning deaths for the period 2010 to 2024 by child age in years.

	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).*

51. Since the compilation of that report – there has been a further fatal drowning of a child aged below four years. In June 2024, a two-year-old child drowned in a water catchment on a rural property after leaving home unobserved.

52. I further note that for the purposes of Deputy State Coroner Spanos' investigation into the death of BK, she asked the CPU to compile updated statistics about drowning deaths of young children in water bodies such as ponds and dams on residential properties.

53. The CPU subsequently identified 12 drowning deaths of children aged between newborn to four 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 (this included the June 2024 fatal drowning of a two-year-old in a water catchment);

(b) four drowning deaths in a fishpond or pond (this included Baby LA);

(c) two drowning deaths in buckets; and

(d) one drowning death in a septic tank.

The importance of safety around water for young children

54. The CPU noted that children aged one year represented the highest age group of drownings, followed by those aged two years. It is notable that children at this age or toddlers become more mobile and are curious about their environment and are unpredictable.

55. This is recognised by the Australian Water Safety Strategy 2030:[7]

> *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.*

56. 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:[8]

> *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.*

[7] Australian Water Safety Council, *Australian Water Safety Strategy 2030*, Sydney: Australian Water Safety Council, 2021, p.16.
[8] 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.

57. I reiterate Deputy State Coroner Spanos' summary of the comments made by our fellow Victorian coroners regarding child supervision around water identifying the following safety themes:[9]

(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 posed by bodies of water;

(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.

58. The Australian Water Safety Strategy 2030 includes activities to support messaging about the importance of active adult supervision, such as:[10]

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

59. Her Honour's edifying words regarding BK are relevant here. Baby LA was 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.

[9] Emphasis added.
[10] Australian Water Safety Council, *Australian Water Safety Strategy 2030*, Sydney: Australian Water Safety Council, 2021, p.17.

60. I echo Deputy State Coroner Spanos' plea that 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 at risk of unintentional drowning in *all* types of bodies of water.

61. I convey my sincere condolences to Baby LA's family for their loss and acknowledge the profound grief caused by the passing of such a young child as well as the heart-breaking circumstances in which his passing occurred.

DIRECTIONS

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

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

Mrs EW and Mr DP, senior next of kin

Monash Health

Commission for Children and Young People

Life Saving Victoria

Victorian Building Authority

Detective Senior Constable Rachel Wallace, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 09 December 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.