IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 007475

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner David Ryan
Deceased:	Ivy Bella Roze Egan-Lee
Date of birth:	6 August 2020
Date of death:	26 December 2024
Cause of death:	Hypoxic ischaemic encephalopathy following immersion
Place of death:	Royal Children's Hospital 50 Flemington Road Parkville, Victoria
Keywords:	Pool safety – safety barrier – boundary fencing - inspections

INTRODUCTION

1. On 26 December 2024, Ivy Bella Roze Egan-Lee was 4 years old when she passed away at the Royal Children's Hospital. At the time of her death, Ivy lived in Morwell with her mother, Rhiannon Egan-Lee, her brother, Jayden Speakman, and her grandmother, Kelly Sutherland. Ivy is warmly remembered as an engaging and energetic girl and she is deeply mourned by her family.

BACKGROUND

2. In February 2024, Ivy and her family moved to a rental property at 26 Spring Court, Morwell. The neighbouring property, at 24 Spring Court, has an inground pool in the backyard. The pool had been installed in the 1980s. The boundary between the two properties was a timber fence which consisted of concrete posts, horizontal rails and vertical palings (**the boundary fence**).

3. Ivy had limited exposure to swimming pools in her life and had not yet learnt to swim.

4. The property at 24 Spring Court was owned by Chaka Cook. He purchased the property in early 2024 from Josephine Marek, and moved in on 6 April 2024. Mr Cook has autism and his parents assisted him to fund the purchase of the property. There was a dwelling at the rear of the property which Mr Cook sublet to a tenant, James Garrett, although he had moved out by December 2024.

5. In order to complete the sale of the house, Ms Marek was required to have the pool inspected and certified as compliant with the *Building Regulations 2018* (**the Regulations**) by an inspector. A compliance certificate must be lodged with the relevant council every four years. For pools constructed before 8 April 1991, the Regulations require a pool to be surrounded by a safety barrier which may be constituted by a boundary paling fence shared with a neighbour. This is also the case with more recently constructed pools which are required to comply with the Australian Standard (AS1926.1-2012).

6. It is a pool owner's responsibility to ensure that a pool safety barrier is properly maintained, including where the safety barrier is constituted by a shared boundary fence with a neighbour. The checklist published by the Victorian Building Authority (**VBA**)[1] states that *"barriers*

[1] Now trading as the Building and Plumbing Commission. The checklist is intended to provide guidance to pool owners with maintaining safety around the pool.

should not be able to be easily pushed over or physically damaged, reducing the effectiveness of the barrier".[2]

7. On 18 February 2024, an experienced registered Building Inspector, Kenneth Bruhn, attended 24 Spring Court to conduct an inspection of the pool pursuant to Division 2 of Part 9A of the Regulations. One of the non-compliant issues identified in Mr Bruhn's report was that the *"timber paling boundary fence had some missing/broken palings/palings coming away from the timber rails"*. Ms Marek subsequently arranged for the fence to be repaired by a relative. Ms Sutherland had been at home when the repairs were carried out and she recalled that no new palings were installed, rather loose palings were nailed back in place.

8. On 28 February 2024, Mr Bruhn conducted a further inspection at 24 Spring Court and assessed that the pool safety barrier was compliant with the Regulations, including the shared boundary fence with 26 Spring Court, and issued a Certificate of Barrier Compliance to Mr Cook. Mr Bruhn stated that during the inspection, and consistent with the checklist published by the VBA, he:

   "confirmed that the missing palings had been replaced and securely nailed in place. A check was conducted of all the palings to make sure they were secured in place and had sufficient structural integrity and strength. I walked along the side of the boundary fence and checked the palings which were found to withstand considerable pushing effort. The fence still retained a deteriorated appearance but at the time of inspection, I was satisfied that the strength of the fence and its components was compliant under Part 9A, Div 2, Building Regulations 2018".

9. Mr Bruhn also stated that he made Mr Cook aware of his ongoing obligations to maintain the safety barrier and that he should consider future replacement of the boundary fence.

10. By the middle of the year, the boundary fence had begun to fall into disrepair after being damaged in high winds. In particular, an extension which had been installed along the top of the fence for privacy had fallen down. Further, Rhiannon recalled having to push pieces of the fence back into place over time. She stated:

    "We had a few pieces of fence pushed back into place over time as the top palings kept leaning off the main fence a bit. I have pushed them back in a few times when I noticed they were off

[2] https://www.vba.vic.gov.au/__data/assets/pdf_file/0009/99216/VBA-Pool-and-Spa-Safety-Barrier-Self-Assessment-Checklist-1.pdf.

but it would always come off over short time…These palings are the section where Ivy was able to get through which was never fixed".

11. Also, Mr Garrett, who moved into 26 Spring Street around this time, described the fence as "*functioning but looked to need some maintenance and looked old and a bit dated"*.

12. Around this time, Mr Cook recalled it as June or July 2024, he visited Rhiannon and they spoke about replacing the entirety of the fence. Despite Mr Cook's willingness to replace the fence, further positive steps were not taken to ensure that it was done.

13. In October 2024, Mr Garrett noticed a gap in the boundary fence about 10 centimetres wide which had been created by a paling that had come loose but which he observed *"could easily be fixed maybe with some new wood and a nail"*. He also noticed some toys near the pool which he assumed had been thrown through the gap in the fence by the children living at 26 Spring Court. He recalled speaking with Ms Sutherland at this time who acknowledged that the paling in the fence needed to be repaired. He recalled that he relayed this conversation to Mr Cook. Mr Garret noticed that the next day the paling had been shifted back into place.

14. Mr Cook stated that he believed the boundary fence was *"fully functional and never noticed any issues with it"*. He further stated that "*No one ever brought it to my attention there was an issue with it or faulty (sic). However in November 2024 I did notice a crack in the fence that was about 3cm long if that and this was approximately in line with my side gate so a few metres away from the BBQ brick wall area".*

THE CORONIAL INVESTIGATION

15. Ivy'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.

16. 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.

17. 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.

18. Section 7 of the Act provides that the coroner should liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations; and to expedite the investigation of deaths.

19. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ivy's death. The Coronial 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. I have also considered correspondence from Ivy's mother relating to prevention opportunities.

20. This finding draws on the totality of the coronial investigation into Ivy's death including evidence contained in the coronial brief, correspondence from Ivy's family and submissions from the legal representatives of Mr Bruhn and Mr Cook. While 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.[3]

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

Circumstances in which the death occurred

21. On 17 December 2024 at around 1.00pm, Ivy was playing in the backyard of her house with her cousin, Caitlyn, who was the same age. Rhiannon was inside talking on the phone with her father while Jayden was in his room playing video games. Ms Sutherland was visiting the house of her other daughter in Traralgon and Mr Cook was not at home next door. Some minutes later, Caitlyn yelled out to Rhiannon that Ivy was in the neighbour's pool.

22. Rhiannon was able to see Ivy floating face down in the pool from the back door and she immediately ran outside and launched herself through the boundary fence and into the pool. She pulled Ivy out of the pool and commenced cardiopulmonary resuscitation (**CPR**). Shortly afterwards, Jayden came outside and assisted by contacting emergency services at 1.23pm.

[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.

Some neighbours also heard Rhiannon screaming and contacted emergency services and came to assist.

23. Victoria Police arrived at the scene at 1.29pm and took over the performance of CPR. Ambulance Victoria arrived shortly afterwards at 1.31pm and took over the emergency response. Fire Rescue Victoria also attended the scene. Rhiannon told police that she had last seen Ivy about 4 minutes before finding her in the pool. Ivy was observed to be hyperthermic and to be in cardiac arrest, but return of spontaneous circulation was achieved at 1.53pm. She was intubated and transported to the Royal Children's Hospital by helicopter.

24. Acting Sergeant Griffith who attended the scene noted that *"the fence appeared extremely weathered and flimsy"* and he did not *"believe it would have been able to support a person climbing over it"*. Detective Senior Constable John Park observed that the *"fence was run-down, and had a number of loose palings throughout the entire fence both at the top and bottom"*. It appears some damage to the fence occurred when Rhiannon passed through it to get to her daughter and further palings were removed to enable police to get access to the scene. The state of the fence observed by police is consistent with the photographs taken at the scene.

25. At the Royal Children's Hospital, a Magnetic Resonance Imaging (**MRI**) scan revealed that Ivy had suffered a severe hypoxic brain injury. She passed away on 26 December 2024.

Identity of the deceased

26. On 26 December 2024, Ivy Bella Roze Egan-Lee, born 6 August 2020, was visually identified by her mother, Rhiannon Egan-Lee.

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

Medical cause of death

28. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine conducted an examination on 31 December 2024 and provided a written report of his findings dated 3 January 2025.

29. Toxicological analysis of ante-mortem samples identified the presence of fentanyl and midazolam, which were administered in the course of emergency medical treatment.

30. Dr de Boer provided an opinion that the medical cause of death was *1(a) Hypoxic ischaemic encephalopathy following immersion*.

31. I accept Dr de Boer's opinion.

FURTHER INVESTIGATIONS

32. Mason Tennant, a Municipal Building Surveyor at the Latrobe City Council inspected the boundary fence on 18 December 2024. He *"observed the timber paling portion of the swimming pool safety barrier has been significantly affected in that, the timber palings and horizontal railings of the fence/barrier are unsupported and liable to collapse"*. He further stated that the *"horizontal rails were not properly connected to the concrete posts, and the palings would fall off with the slightest amount of force (I accidently knocked one over while carrying out a check of the palings). The fence was not serviceable…"*

33. Mr Tennant issued an Emergency Order under the *Building Act 1993* requiring Mr Cook to, among other things, construct a new, structurally rigid timber paling fence forming a portion of the swimming pool safety barrier and obtain and submit a new Certificate of Barrier Compliance. Mr Tennant also noted that temporary works had been carried out to ensure that the safety barrier complied with the Regulations and that Mr Cook was making arrangements to replace the boundary fence.

34. Mr Tennant has referred the matter to the VBA for investigation. The investigation is completed and the Authority is assessing next steps, which may include both disciplinary action and prosecution.

35. On 23 January 2025, Mr Cook arranged for the pool to be inspected by Building Inspector, Darren Hood. It was clear from Mr Hood's report that the boundary fence with 26 Spring Court had been replaced with a new wooden paling fence. Mr Hood found that the fence complied with the relevant standards. After Mr Cook addressed a number of non-compliances relating to other features of the safety barrier, Mr Hood issued a Certificate of Barrier Compliance to Mr Cook on 7 February 2025.

FINDINGS AND CONCLUSION

36. I am satisfied that Ivy was able to crawl through a gap in the boundary fence into the neighbour's yard. She had then removed her clothes before getting into the pool and not being able to swim, became immersed in the water and then unconscious. Her cousin observed her

go into the pool and notified Rhiannon. It is not possible to determine exactly how long Ivy had been in the pool before she was discovered by her mother but she told police that it was around 4 minutes.

37. The circumstances of Ivy being found in the pool and the subsequent efforts to provide emergency treatment were extremely traumatic for her family and first responders. They are commended for their sustained efforts in very distressing circumstances. Mr Cook has also been very distressed by Ivy's death and I am satisfied that he did not foresee the risk that was presented by the condition of the boundary fence.

38. Notwithstanding the inspection and certificate issued in February 2024, I am satisfied that the boundary fence was not compliant with applicable barrier standards less than 10 months later. As a result, Ivy had the opportunity to be able to crawl through a gap in the fence and gain access to the pool.

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

    a) the identity of the deceased was Ivy Bella Roze Egan-Lee, born 6 August 2020;

    b) the death occurred on 26 December 2024 at the Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria, from hypoxic ischaemic encephalopathy following immersion; 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.

1. It is critically important for pool owners to understand that they are solely responsible for maintaining a safety barrier including when it may be partly constituted by a boundary fence shared with a neighbour.
2. The Victorian Building Authority provides the following relevant guidance on its website:
   It is the pool owner's responsibility to ensure the pool safety barrier is maintained, fulfils its purpose and continues to achieve compliance for the life of the pool.

   Careful attention should also be taken where the safety barrier relies on a shared boundary fence with an adjoining owner. This does not become a shared responsibility with the pool owner's neighbour.

This is the sole responsibility of the pool owner to ensure the safety barrier is properly maintained.

The adjoining owner is not responsible for the compliance and maintenance of the shared fence that the pool owner is relying on as a pool safety barrier.

3. It is also critically important that when considering whether to issue a Certificate of Barrier Compliance under the Regulations, inspectors carefully assess the likelihood of a safety barrier becoming non-compliant with the Regulations within the four-year life cycle of that certificate.
4. The Victorian Building Authority contains the following relevant guidance to inspectors on its website:
   It is strongly recommended the inspector considers the four-year cycle of compliance when undertaking a "point in time" compliance inspection of the pool safety barrier.

   Key factors that form part of an inspector's consideration are the condition and durability of the barrier in relation to the rigidity/structural requirement and any signs of wear and tear or dilapidation that may contribute to a foreseeable non-compliance within the next four years, beyond the necessity of general maintenance.

   However, if the inspector believes it is unlikely to expect the barrier will remain compliant over the four-year cycle, unless altered or amended, then this should be reflected in the determination and compliance decision.[4]

I convey my sincere condolences to Ivy's family for their loss.

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.

[4] https://www.vba.vic.gov.au/surveyors/pool-and-spa-safety-barrier-inspections.

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

Rhiannon Egan-Lee, Senior Next of Kin

Royal Children's Hospital

Victorian Building Authority

KidSafe Victoria

Chaka Cook, c/o Strongman & Crouch

Kenneth Bruhn, c/o HBA Legal

Detective Senior Constable John Park, Coronial Investigator

Signature:

Coroner David Ryan

Date: 06 October 2025

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.