Inquest into the death of William Chase Corben

William Chase Corben, aged four years, drowned in his neighbours' swimming pool on 28 February 2015. William was able to access the pool as the pool gate was intentionally propped open with a block of wood.

Deputy State Coroner John Lock delivered his findings of inquest on 7 April 2016.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported.

Further information relating the implementation of recommendations can be obtained from the responsible agency named in the response.

Recommendation 1

The issue of creating a new offence where serious injury or death occurs in circumstances where there have been intentional or negligent breaches of pool safety laws be reconsidered by the responsible state government minister, in the context of the facts arising from these cases as well as the support for the implementation of such additional offences by other coronial jurisdictions.

Response and action: the recommendation was not implemented.

Responsible agency: Department of Housing and Public Works.

On 25 July 2016 the Minister for Housing and Public Works responded:

The department is reviewing the recommendation and expects to provide a detailed response later in 2016.

On 16 November 2017 the Minister for Housing and Public Works and Minister for Sport responded:

In April 2015 a Pool Safety Consultative Group (PSCG) was formed within the Department of Housing and Public Works (the department) to provide the minister and the department with advice on pool safety issues. Due to the broad range of issues raised by the PSCG and their relevance to a number of government agencies, an Inter-departmental Advisory Committee (IDAC) for Pool Safety was established in June 2015, chaired by the department and made up of representatives from Queensland Health, including Queensland Ambulance Service; Department of Infrastructure, Local Government and Planning; Department of Communities, Child Safety and Disability Services; Queensland Police Service; and the Department of the Premier and Cabinet.

The IDAC considered a number of issues, including whether pool safety offence penalties are adequate to deter non-compliance. Consultation occurred with the Department of Justice and Attorney-General (DJAG) about whether there was a need to increase penalties for current pool safety offences and/or implement additional offence provisions where a child has suffered a serious injury or died because of an immersion incident.

Specifically, the IDAC took into account:

- the loss of a child and associated trauma as a result of an immersion incident

- the need to balance compassion with punishing negligent acts, or any actions, resulting in the immersion incident
- that the *Building Act 1975* contains various penalty provisions with respect to failure to ensure that a gate or door giving access to a regulated pool is securely closed when it is not in use
- that offences under the Criminal Code may apply following a pool immersion incident depending on the circumstances surrounding the incident, including: negligent acts causing harm; leaving a child under 12 years unattended; grievous bodily harm; and manslaughter.

The IDAC recommended that no changes be made to any offences relating to pool safety as it was considered that existing offences in the Criminal Code are sufficient and that offences under the *Building Act 1975* are also at a satisfactory level to address circumstances involving the death or serious injury of a child resulting from breaches of pool safety laws.

The IDAC recommendations were made prior to delivery of the deputy state coroner's recommendations with respect to the inquests of William and T. Therefore, in April 2016, in view of coronial recommendation 1 for these matters, the minister requested that the Attorney-General, and each of the ministers whose departments were represented on the IDAC, advise their position with respect to the IDAC recommendations.

In response to this request the Attorney-General expressed the view that current Criminal Code provisions adequately address the issue and that any stand-alone offence of the type contemplated by the deputy state coroner would be more suitably accommodated within the *Building Act 1975*. The Premier and Minister for the Arts agreed that recommendations of the IDAC be provided to the deputy state coroner, and other ministers whose departments were represented on the IDAC supported the view of the IDAC that no further offences be created where a death or serious injury occurs in a swimming pool where there are intentional or negligent breaches of pool safety laws. The deputy state coroner was advised of this position by letter in September 2016, and provided with a report on issues considered by the IDAC and relevant outcomes in October 2016.

Recommendation 2

The Queensland Police Service review their *Operational procedures manual* Chapter 8.5.11 regarding the investigation of swimming pool deaths to ensure all possible aspects of swimming pool compliance and safety are included in the investigation.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Police Service.

On 12 July 2016 the Minister for Police, Fire and Emergency Services and Minister for Corrective Services responded:

Amendments to *Operational procedures manual* (OPM) section *8.5.11* 'Drownings occurring in swimming pools' have been made to include the following additional information (highlighted):

> When a death occurs as a result of drowning in a swimming pool, the investigating officer should ascertain as much of the following information as is possible and include same on the relevant part of the Form 1: 'Police report of death to a coroner':
>
> (i) whether the pool is in ground or above ground;

(ii) whether fencing around the pool, distinct from fencing around the boundary of the property, exists;

(iii) description of existing pool fencing, including height of the fence, construction materials and method of construction and compliance with legislation;

(iv) the presence or otherwise of pool gates, including detailed description of their operation, additional access areas and if any non-compliant modifications have been made;

(v) details as to why the pool fencing did not prevent the drowning.

The amendments were approved by the deputy commissioner, Strategy, Policy and Performance and published in the *Service Manuals Update* – OPM amendment issue no. 50 on 29 January 2016.