CITATION: *Inquest into the death of Richard John Obrey Baird*

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0016/2014
DELIVERED ON:	14 October 2014
DELIVERED AT:	Darwin
HEARING DATE(s):	22, 23 and 24 September 2014
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Unexpected death by drowning, drainage, secured access to drains, municipal responses thereto.**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
City of Palmerston:	Miles Crawley

Solicitors:

City of Palmerston:	Cridlands

Judgment category classification:	B
Judgement ID number:	[2014] NTMC 020
Number of paragraphs:	71
Number of pages:	24

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0016/2014

In the matter of an Inquest into the death of
RICHARD JOHN OBREY BAIRD
ON 20 JANUARY 2014
AT ROYAL DARWIN HOSPITAL

FINDINGS

Mr Greg Cavanagh SM:

Introduction

1. Richard John Obrey Baird (hereinafter referred to as "Richard") was a vibrant, fun loving, adventurous 8 year old boy. He loved to play and he loved the outdoors. He was a promising student and athlete. He was born at the Royal Darwin Hospital ("RDH") on 11 July 2005 and was of Aboriginal descent.

2. On 19 January 2014, on a very squally monsoonal day, he was playing with one of his brothers and some friends in and around a drain system in Palmerston. He was last seen by his friends getting "sucked in" to the drain and disappearing under the fast flowing water. The alarm was raised and Richard was eventually found 580 metres further along the drain system in a secured drain. It took rescuers approximately a further 15 minutes to extract Richard from that drain.

3. Upon being extracted, cardiopulmonary resuscitation ("CPR") was immediately commenced and Richard was then conveyed to RDH. He was admitted into the Intensive Care Unit ("ICU") but was declared deceased at 5.36pm on 20 January 2014.

4. This death was reportable to me pursuant to s.12 of the *Coroners Act* ("the Act") because it was unexpected and unnatural and appeared to have resulted from an accident or injury. A public inquest was not mandatory, however due to the significant dangers associated with children playing in and around drains, I exercised my discretion to hold a public inquest into the death in accordance with my powers under s.15(2) of the Act.

5. This inquest was held on 22, 23 and 24 September 2014. Ms Jodi Truman appeared as Counsel assisting. Mr Crawley appeared as counsel for the council of the City of Palmerston. A total of nine (9) witnesses were called to give evidence at this inquest, namely; Detective Sergeant Kerry Harris, Mark Callaghan, Cindy McLaren, Jean Hallworth, Simon Kerr, Russell Young, Jason Baird Snr, Martin Prior and Mark Spangler.

6. A brief of evidence containing various statements, together with numerous other reports, police documentation and medical records were tendered at the inquest (exhibit 1). Public confidence in Coronial investigations demands that when police (who act on behalf of the Coroner) investigate deaths that they do so to the highest standard. I thank Detective Sergeant Kerry Harris for his thorough investigation.

7. Pursuant to section 34(1)(a) of the Act I am required to find if possible:

> "i. The identity of the deceased person;
>
> ii. The time and place of death;
>
> iii. The cause of death;
>
> iv. The particulars needed to register the death under the Births, Deaths and Marriages Registration Act;
>
> v. Any relevant circumstances concerning the death"

8. I note that section 34(2) of the Act also provides that I may comment on a matter including public health or safety connected with the death being

investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

> "(1) A Coroner may report to the Attorney General on a death or disaster investigated by the Coroner.
>
> (2) A Coroner may make recommendations to the Attorney General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the Coroner.
>
> (3) A Coroner shall report to the Commissioner of police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the Coroner believes that a crime may have been committed in connection with a death or disaster investigated by the Coroner".

Background

9. Richard was the sixth child of Alison Gadayurr Wunungmurra and Jason James Baird. He had seven (7) other siblings with whom he was very close. He lived with his parents and siblings in the Palmerston suburb of Gray and attended the local primary school. He had a natural ability for sport and played rugby for the Palmerston Cowboys and the Brothers League clubs as well as AFL for his school's under 10 side.

10. I received evidence that he was also a very good student and attended school on a regular basis. He was clearly a very much loved, and greatly cared for, little boy who is obviously very missed by all those who knew and loved him, most particularly his family. Richard's father, Jason Baird Snr, gave evidence before me. Both Mr Baird Snr and his wife, Alison Wunungmurra, were in court every day of the inquest and despite their obvious and continued grief they showed remarkable courage and strength. They provided a letter at the close of proceedings that was read out by Counsel

Assisting. It was deeply moving and showed just how loved and well cared for Richard was by them. They described themselves in that letter as being very lucky to have had Richard as their son. Likewise it is clear that Richard was very lucky to have them as his parents.

Events on 19 January 2014

11. I received evidence that on 19 January 2014, Richard woke early and, after eating breakfast, left home with his older brother Jason James Baird Jnr, aged 10 years. The two boys left at about 10.00am and thereafter met up with Leo Barry aged 11 years and Brian Shadforth aged 6 years. All four boys remained together playing in and around the Gray Shops and the Primary School area. In the early afternoon they found an abandoned shopping trolley near the bus stop at Gray School. They pushed that trolley to a nearby drain located approximately 100 meters from the bus stop and used it to prop open the grate on the drain.

12. The audio statements of the boys as to the events of that day were played in open court. The boys described gaining access to the drain by moving the grate. Precisely how they did that is a little unclear. Reference was made to using a rock to break the bolts, but it was difficult to establish from their evidence as to which drain they were actually referring to. Despite this lack of clarity I determined it was not necessary to require any of the boys to come to court to give evidence in what would be very distressing circumstances for such young children. It is clear that, however it was achieved, these young boys were able to eventually lift the grate over the drain and gain access. Thereafter, all four boys played in the drain system on that day.

13. There was reference by some of the boys in their statements to having done this on previous occasions. Mr Mark Callaghan is the caretaker at the Gray Primary School and he described having seen some boys “hanging out” around the drains in the days leading up to this death. Mr Callaghan could

not be certain however if Richard was amongst the boys that he saw. On Thursday 16 January 2014 he spoke to a group of about five boys and told them not to hang around the drains. He walked over to the drain where they were and noted that the grate appeared to be bolted down by two (2) dyna bolts. He only checked one side however and did not check if all sides were similarly bolted down.

14. On Saturday 18 January 2014 he again saw the boys playing near the drain area and spoke with them again. This time he explained the dangers of the drains. He told the boys a story from NSW where a "young kid on a boogie board got dragged" about 10 kms through a drain. He tried to get the message of the dangers of playing in drains through to the boys. Mr Callaghan did not see the boys again on the Sunday prior to this death.

15. A number of persons did however see some boys playing in the drains on Sunday. In fact not long prior to Richard disappearing, Ms Cindy McLaren was walking in the area and saw some boys in the drain and spoke to them. Although she was unable to say for certain whether it was Richard and his friends. Ms McLaren gave evidence that she saw three boys playing *inside* the drains near the location where Richard disappeared. There was a bar across the drain where she saw the boys and she was unable to reach them, but she told them to "get out". Ms McLaren gave evidence that after this conversation she noticed there was a trolley propping open a grate not far from where she had spoken to the boys inside the drain. As a result she was concerned for their safety and ran home to call the police about what she had seen. By the time she got home she was "drenched" from the rain and remembered her call to the police being made at about 2.33pm.

16. Whilst Ms McLaren stated she could not be certain it was Richard that she saw in the drain that day, I am satisfied that it was Richard and his friends that she saw. The close proximity in time to when she saw these boys and to the time of Richard's disappearance, and the close proximity of the location

where she saw them to the location of his disappearance, leaves me satisfied it was Richard and his friends.

17. As previously noted, by the time Ms McLaren arrived home she was drenched by the rain. The boys themselves describe rain occurring whilst they were in the drains. The weather on 19 January 2014 was, on any description, wet and overcast. There had been a number of squally monsoonal showers throughout the day. I had tendered into evidence the Bureau of Meteorology records for the daily rainfall that day. There was a total of 106.2mm of rain compared to only 38.2mm the day previous.

18. As a result of the weather, the water levels within the drains rose rapidly. All three boys referred to seeing Richard jump into the drain and then immediately disappearing under the fast flowing water. To use their description, they saw Richard get "sucked in" to the drain. Upon this occurring, the boys began yelling for help and attracted the attention of nearby neighbours who immediately called police.

19. Ms Jean Hallworth was one of those neighbours. She lives in a property which abuts the location where the boys used the trolley to prop open the drain. She gave evidence that she heard the boys playing outside that day and initially thought they were just playing in the puddles and was not concerned because this was something that occurred regularly. She stated that she had never seen the grates to the drain propped open before and therefore had no concerns prior to this date that the children were actually *in* the drain. Later however she heard noises that made her think they were in the drain and then shortly thereafter she heard the boys calling for help.

20. Ms Hallworth stated that she immediately went outside to where the boys were and one of the boys said to her "He's gone". She looked into the drain and stated that at this time the drain was nearly completely full of water with only a very small area available for air. She did not have a phone on her and so she went out to the street to try and stop a passing car to get help.

21. One of the people approached for help was Mr Simon Kerr who was driving home. Mr Kerr recalled being approached by a "distressed woman" who told him that a boy had "gone down the drain". After having the drain pointed out to him, Mr Kerr went over and could see the trolley still in position. He looked into the drain and described the water as being deep and "flowing very fast".

22. Mr Kerr established the direction that the drains flowed and began walking to each drain, looking inside each one as he went along. He described that as he walked along the drains the water was "roughly ankle deep" but as he progressed it "started getting deeper". Mr Kerr continued searching and noted that where he was searching in was getting "towards mid-thigh height". He then noticed water "spurting up" and knew this meant there was another drain in that location that was submerged. He moved towards the drain and that was when he saw a child's hand in the water. This was some 580 metres from where Richard had originally jumped into the drain system.

23. Mr Kerr reached down to grab Richard's hand and that was when he realised there was a piece of REO (or reinforcing) bar across the drain. This is a steel bar commonly used in and around drains. I received evidence that this drain was of concrete construction and had a small opening of 75 cms through which the ¼ inch REO bar ran. Mr Kerr stated it was clear that the bar would need to be removed in order to get Richard out. He could see Richard's head was right next to the opening, but it was still under water. Mr Kerr attempted to pull Richard out and to get his head into a position so that it was out of the water, but by this time the water was approximately one (1) foot over the drain.

24. Mr Kerr yelled out for help. Police had by then arrived and shortly thereafter the Fire Service. Fire fighter Russell Young gave evidence as to his; and his fellow officer's, obviously heroic attempts to rescue Richard. Unfortunately, because of the placement of the REO bar it was simply

impossible to remove Richard from the drain quickly. Mr Young described the depth and the force of the water in the area and how even he and his fellow officers, as fully grown and very strong men, had difficulty keeping their ground. It appears from the materials tendered that, despite the considerable efforts of attending police and firefighters, it took approximately 15 minutes before Richard could be extracted and even then only after the use of the "jaws of life". It is clear that police and firefighters who attended that day did everything they could to attempt to remove Richard from the drain as quickly as possible.

25. Richard was extracted at approximately 3.00pm, but by then he was in full cardiac arrest. CPR was commenced immediately first by Fire Fighters and then by Paramedics. He was conveyed to the RDH by ambulance and arrived at approximately 3.36pm. CPR was continued until 3.56pm, by which time he had been intubated, ventilated and his condition was described as being very unstable. He was admitted to ICU where he passed away the following day at 5.36pm.

Cause of Death

26. In this case I determined that it was not necessary for an autopsy to be performed as it was clear from the opinion of the relevant medical professionals that the cause of death was uncontroversial. I therefore received, in lieu of an autopsy, a report from Dr Dianne Stephens who is the Director of the ICU at RDH. Dr Stephens reported that by the time Richard was intubated, ventilated and able to achieve spontaneous circulation, his condition was very unstable. The total time of cardiac arrest was "more than an hour" and he had shown "signs of severe brain injury". Richard's pupils were fixed and dilated and he "remained completely unresponsive from the time of his rescue". Overnight he remained "very unstable and his vital organs all began to fail".

27. Dr Stephens reported that by the morning of 20 January 2014 it was "evident" that Richard:

> "…was not going to survive his injury. He remained completely unresponsive with loss of brain stem reflexes, he had a severe lung injury that was deteriorating despite maximal supportive therapy and 100% oxygen, he had low blood pressure despite maximal treatment with inotropic drugs, his kidneys were failing and his blood was no longer clotting. Due to the severe physiological instability it was not possible to complete brain death testing though all the reflexes that could be tested were absent and it is my considered opinion that (the deceased) was ***almost certainly brain dead from the time of the rescue***". (My emphasis added).

28. On the question of the cause of death, Dr Stephens reported that the cause was hypoxic brain injury and multi-organ failure as a result of drowning. It is clear that at the RDH, and particularly the ICU, that all that could be done to treat Richard was done and their care of this young boy was exemplary.

The drains

29. The drains which Richard and his young friends accessed and were playing were located in the suburb known as Gray in Palmerston. The City of Palmerston is a local government area of the Northern Territory situated between the outer industrial areas of Darwin and the rural areas of Howard Springs. It has its own council and was incorporated in 1981 under the *Local Government Act (NT)*. The elected council consists of the Mayor and six Aldermen and is known as the "City of Palmerston Council" ("the Council").

30. Mr Mark Spangler is the Director of Technical Services for the Council. As a result he is in charge of Engineering Services which includes roads and drains, environmental services, waste management, asset management, town planning and ranger services. Mr Spangler confirmed that it is the Council who is ultimately responsible for the drains located in the City of Palmerston and that Council has its own officers inspect those drains "as

resources permit" and also outsources maintenance work. Mr Spangler noted that the grates and drains where the boys were playing appear to have been established by the Palmerston Development Authority in about 1982. I note that this is shortly after the City of Palmerston was first established.

31. Mr Spangler identified that at the time of this death, the Council's inspection procedures only identified "defective" infrastructure, i.e. it did not record infrastructure that was in good order. The procedures at that time also did not inspect the drains on a fixed schedule, i.e. there was not a specified period of time during which drains were required to be inspected. As a result it was not possible to be precise as to when the relevant drains had last been inspected. However Mr Spangler did state that the "last known full inspection" of the drainage system in Gray occurred in December 2012.

32. Mr Spangler also provided a copy of the maintenance purchase orders for the years 2012, 2013 and 2014. Those records include purchase orders for the drainage system where this death occurred, i.e. the Confalonieri drains. There is an order dated 11 December 2012 which identifies that the inspection of the drainage system in Confalonieri Drains resulted in the need to "remove silt and debris build up".

33. There is also an order dated 24 June 2013 for repairs to a stormwater drain in the area. Mr Spangler stated that whilst this is not the same drain in which Richard was located, it was an adjoining pit and he considered it would be "unusual" if the maintenance crews did not inspect the other drains in the area at the time given they were conducting works in the area. There is no actual evidence however that this did in fact occur.

34. Mr Martin Prior also gave evidence before me. Mr Prior jointly operates, and is employed by, a business known as "JLM Civil Palmerston" which has a contract with the Council to carry out a range of civil works in Palmerston. This includes carrying out inspections and maintenance of the drains in

Palmerston. Mr Prior has been operating that business with his brother in law since approximately June 2012. Mr Prior said in his statement to police that their contract with the Council at the time of this death was that:

> "There was no schedule in place for maintaining the drains. When something needed to be repaired, the Council would call us".

35. Mr Prior could not recall undertaking any repairs in the area where Richard and his friends had been playing in the drains prior to this death. He stated that he could not recall having done any previous work on the particular drain involved. He confirmed the content of his statement where he stated:

> "… in fact I don't think we have done any work on drains in that area prior to that death".

This evidence contradicts the evidence given by Mr Spangler as to his belief as to works being undertaken in that area by JLM Civil. This is a good example of the inadequacies of the Council's previous inspection procedures.

36. Mr Prior was called to the drains on the day that Richard had been extracted from the drains and was tasked to reinstate what he referred to as a "grate" to the "open space drain". Mr Prior stated that when he got to the drain, the shopping trolley that had been used to prop open the drain was to the side. He noted that the grate itself had two (2) bolts missing. Mr Prior formed the opinion that the bolts appeared to have been removed recently. He carried out repairs that day and returned to complete the works sometime thereafter. he stated that the only other work he was requested to do was check the bolts on the other drains and replace any that were missing or "so rusty that they could be kicked off".

Dangers of the drains

37. There is no doubt that drains represent a risk of danger to persons when they are flowing with water and particularly when they are overflowing, like they

were on this day. Two (2) previous deaths that have been reported to my office of drownings that have occurred in the drain system in Palmerston. The first was in 2008 of a 10 year old boy in a stormwater drain in Elrundie Avenue and the second in 2010 of a 45 year old man in a "v-shaped" drain at Mitchell Creek in Rosebery.

38. There is also no doubt that children, as a general rule, are attracted to water and that generally children, and arguably particularly boys, like taking risks and being "adventurous". Drains can therefore represent unique opportunities to combine that risk taking behaviour with water. Care therefore needs to be taken.

39. It is equally true however that drains have to exist. Where communities are established, so too must drainage systems be established. Their existence is therefore a fact of life and they cannot be avoided. Consequentially as a community we need to do all we can to make the locations of drains as safe as possible and reduce the risks associated with the drains as much as possible.

40. One way of reducing risk is through warnings, advice and education about the risks and dangers associated with drains, particularly education of our children. I received evidence from the Royal Life Saving Society of the Northern Territory ("RLSSNT") of their various initiatives, strategies, programs and reports relating to water safety across the Northern Territory (exhibit 6).

41. One of the initiatives is a campaign known as "The Pipes and Drains" campaign. I received evidence that this campaign in fact arose as a result of the 2 previous drownings (as earlier mentioned) in the drains in Palmerston. It was based on a campaign that commenced in Cairns which had similar issues and environment. It was first launched in 2008 and was collaboratively funded by the Northern Territory Government (NTG), City of Darwin and City of Palmerston. It generally runs from November to

February each year and is reviewed every September during "Water Safety Week".

42. A question that arose during this inquest was whether that campaign was appropriate. I am aware that this was of particular concern to the family who were concerned that the use of cartoon characters may not be appropriate in warning children *against* drains. Whist I understand and appreciate the concern raised by the family, I do find that the three boys who were with Richard on this day were aware of the dangers and risks associated with the drains. I therefore find that I can reasonably infer that Richard was also aware of the dangers.

43. There was reference by the boys in their audio statements to the "Don't play in Pipes and Drains" campaign. One of the boys in fact sang part of the song related to the campaign during his recorded statement with the police. In addition one of the boys spoke of how the group had in fact pretended they were "sittin down watchin" when they saw some police drive past them on that day. This shows that they knew they would be in trouble if they got caught playing in the drains. One of the boys also acknowledged that he had been "asked" by his mother not to play in the drains but:

> "… I never listen to her".

44. Whilst pipes and drains represent a risk of danger to all, and particularly children, it is not possible to sanitise and make completely safe all places in our community. I consider that the "Pipes and Drains" campaign is one that appears to draw the attention of children to the risk and dangers associated with pipes and drains and I make no criticism of that campaign despite the concerns raised by the family.

Response by City of Palmerston Council to the risks/dangers of drains

45. As noted earlier, Mr Spangler gave evidence on behalf of the Council. He described the drain that the boys accessed as a "trunk drain" which, unlike

most drains, is designed to allow water to flow out of the pit, rather than just into it. As a result, in times of high flow, water will overflow out of the pit and into the above ground floodway. Mr Spangler stated that this is deliberately designed to cause water to overflow and then drain away gradually as the water subsides.

46. The grates for the trunk drains are bolted down on all four corners, whereas normal storm water drains are not usually bolted down as their own weight holds them in place. Mr Spangler advised that the Council maintains approximately 7,500 drainage pits, most of which are normal storm water drains. Mr Spangler stated that he considered the drainage system to be appropriate for the area as no flooding has been reported in the area and all roads remain open during significant rains.

47. It is to be noted that the four young boys gained access to the drains (according to their own statements) on their own. As a result, concern was raised as to whether it is adequate to simply rely on bolts to keep the grates secure. Mr Spangler gave evidence that it was his opinion that it was "impractical" to secure grates in a way that made them "absolutely inaccessible" on the following bases:

    47.1 Maintenance workers needed to be able to access the pits to remove blockages, debris and silt. It was therefore not practical to weld the grates down and grind them open every time access was required and doing so represented a risk of increased danger to the workers and could not occur in a timely fashion.

    47.2 Installing padlocks on each and every grate was also not practical due to the cost involved but also the inconvenience and the high risk that the locks themselves would corrode or the key hole would itself become blocked.

48. Mr Spangler stated further that he was not aware of any location "in the world" where each and every pipe and drain was secured by either welding or by lock and key and that neither the City of Darwin nor Litchfield Councils used these measures to secure their drains. I accept this evidence

49. A further concern raised on the materials was whether the pipes and drains were inspected on a sufficiently regular basis so that any inadequacies, such as the absence of bolts, could be remedied. As noted earlier, Mr Spangler gave evidence that at the time of this death Council had its own officers inspect the drains "as resources permit" and not on a fixed schedule. He also noted that their inspection procedures only identified defective infrastructure and did not record infrastructure that was in good order.

50. Mr Spangler gave evidence that Council had been reviewing their infrastructure inspection procedure from about early 2013, i.e. prior to this death and that as a result Council had received a "Risk Based Infrastructure Inspection Manual" which they were trialling as from late 2013. That Manual included a requirement that drains be inspected at least once every 12 months. The Manual was formally adopted by the Council on 18 February 2014 and resulted in the creation of two new positions which involve the systematic periodic inspection of all road and drainage infrastructure every 12 months.

51. On the issue of the adequacy of inspections every 12 months, I note that Detective Sergeant Harris sought advice from Councils located in Cairns; where there are similar tropical weather conditions, and also from the City of Darwin, as to how regularly they conduct their inspections. I note from the responses received from the Councils in Cairns that inspections are carried out annually in those locations, i.e. again every 12 months. The City of Darwin Council however carries out inspections twice per year; being before and after the Wet season. I will return to this issue later in these findings.

52. Mr Spangler also referred to the "Pipes and Drains" campaign and noted Council's involvement. Mr Spangler stated that following this death there was concern as to whether the cartoon character advertising conveyed the message of the dangers of drains adequately. Council therefore investigated their own options and in fact obtained a grant for safety purposes and set to work designing its own signs. The finalised design is based on a more traditional "danger" sign and a copy was tendered in evidence (part of exhibit 8). Although I make no criticism of the "Pipes and Drains" campaign, I find Council's approach in relation to these signs to be proactive and they are to be commended.

53. Given the extreme tragedy of such a young life being taken as occurred here, there has also been considerable public interest in the circumstances surrounding this death. As a result, I also received evidence from a group of concerned citizens who had established a "Facebook" group known as "Time for Action, Safer Pipes and Drains for Palmerston NT" ("the Time for Action group"). This group was established in March 2014 in the wake of the death of Richard. It states on its Facebook page that it had:

> "… been created by a group of citizens to raise awareness and discussion on the issue of storm drains, pipes and pits in the Palmerston area".

54. The Time for Action group provided material as to attempts made to deal with the Council in relation to issues and concerns it had about storm drains, pipes and pits in the Palmerston area (exhibit 5). It was clear from the exhibited material that the group felt its concerns had not truly been listened to by the Council and that the needs of the community with respect to making their storm drains, pipes and pits safer were not being provided for. This was a concern shared also by the family of Richard. In particular the group identified a number of storm drains, pipes and pits in the Palmerston area that they considered were unsafe and in need of inspection by the Council and yet they believed Council had done little to assess those areas

and to carry out any necessary works. They also provided examples of where reports had been made as to damaged or dangerous infrastructure, but such reports had not been addressed in a timely fashion. Fundamentally they did not consider that the Council was taking the issue of the safety of the storm drains, pipes and pits seriously enough. Again this was a concern shared by the family.

55. As to these matters, Mr Spangler gave evidence that prior to this death there was (and remains) a system in place where residents can report damaged infrastructure to the Council on a 24/7 basis. If a resident makes contact after hours they are required to follow a number of "prompts" in order to speak with a person. An interstate company is engaged by Council to manage calls that occur after hours. Council also has its contractors available to respond at any hour of the day. Mr Spangler confirmed that there had been some "teething problems" with a new email system since its introduction in July 2014, however he believed those issues had now been addressed. Mr Spangler also stated that Council was looking at ways to increase public awareness of these services. In relation to these matters I consider that Council is being proactive and I make no further comment in this regard.

Conclusion

56. The passing of this bright, active and funny young boy is a terrible tragedy for his family but also for the wider community at large. He was playing with his brother and friends on a wet day, doing what little boys do when they are able to play together; they go on a discovery. It is trite to say that children are by nature curious and there is no reason to think that Richard and his friends were in any way different to other children. They clearly saw a place that they might be able to "discover" in the drain system. It looked exciting. It had rushing water. It is of no real surprise that they would attempt to find a way to access that potentially exciting new world to play and investigate. That is why communities have safety campaigns

surrounding pipes and drains because it is obvious that this is precisely the sort of dangerous place/activity that children may be attracted to.

57. As I stated during the course of this inquest, whilst children are often seeking excitement and are curious and inquisitive, they also lack an adult's appreciation of danger. It is because of that reality, that great care needs to be made to ensure that children **cannot** access storm drains, pipes and pits easily. It is clear however that somehow, on this particular day, these children were able to access the drain system. I find also that it did take some effort on behalf of these boys to gain access to the drains. Quite simply – they wanted to get in. In such circumstances I accept that it is not possible to put in place measures to avoid *all* manner of possible, and/or concentrated, attempts at access. It is also not solely the responsibility of local Councils to ensure that children do not access such areas. It takes a whole of community approach, including parents, guardians, schools and the community, to ensure our children are educated about the dangers that pipes and drains represent and to ensure that they know not to play in or around these locations.

58. In this regard, these boys were seen by a number of persons who *did* in fact tell them to stay out of the drains and warned them that they were dangerous. Richard and his friends ignored those warnings and ultimately Richard paid with his life because they did not listen and continued to play. I do not criticise in any way the persons that spoke to the children on that day, or in the days leading up to this death. They did all that they could. They were not the parent or guardian of the children, nor were they the police and they could only do precisely what they did, i.e. tell the children to stop playing there and to warn them of the danger. They should not feel in any way responsible for what ultimately occurred.

59. I note that in their recorded conversations with police one of the boys referred to breaking the bolts by using a rock. There was also some

suggestion that perhaps some type of tool was used, or even that some other third party removed the bolts that enabled the boys to access the drains. It is my opinion that no matter *how* this occurred, the fact of the matter is that four boys aged between 6 and 11 years of age were able to access the drains and that is of significant concern.

60. I note that evidence was given that the bolts used by Council are damaged at the thread to make them "inoperable" in order to prevent access. There was concern expressed about whether this was an appropriate solution to the problem, however I do not have sufficient evidence to make a final determination in this regard. I do consider however that either this act of damaging the thread did not occur to the bolts that were on this particular drain *or* that the attempt to make the bolts inoperable simply did not, or does not, work. In addition, as a direct result of the way in which maintenance was being carried out at that time, it is not possible to establish when the drain system was last inspected or even what was found in order to determine how long this dangerous situation was in existence.

61. Simply put, it is not good enough that this situation has been able to arise and these dangers not identified before Richard's death occurred. In my view the maintenance system which was in operation by Council at the time of this tragic death needs to be improved. It should not be a system that simply *responds* to dangers as and when they are reported. There should also be a system of risk management and risk avoidance.

62. In relation to considering risk avoidance and risk management, I do not consider it adequate that inspections of the drains only occur every 12 months. In my view more regular inspections are required. I acknowledge the evidence provided by the Council that they are in fact responsible for "about 7,500 drainage pits, most of which are normal stormwater drains and therefore the grates and lids are not bolted down". In relation to this death however, I am not concerned with all "7,500 drainage pits". As stated

during the inquest what I *am* particularly concerned with are those drainage pits that Council has seen fit to have secured and which represent a greater risk of danger.

63. I accept that it is impossible to absolutely deny access to all drains. There are occasions where drains must be accessed. However what I *am* concerned about is the security of drains in residential suburbs where it is known there are a large number of children. In the Top End we have a wet season where an inordinate amount of water can fall during each and every season. It is important in those circumstances that the security of these drains, and the safety of our children, is provided for.

64. Given the extremely tropical weather we experience and the monsoonal conditions that impact upon us every wet season, it is my opinion that these types of secured drains should have inspections carried out upon them in the lead up to the wet season, during the course of the wet season and at the conclusion of every wet season. Whilst I cannot find absolutely that such regular inspections *would* have avoided this death, I do find that they *could* have reduced the risk.

65. I note that I expressed similar views during the course of the evidence given by Mr Spangler and identified my desire to see a register compiled of all secured drains and regular inspections of those drains to be undertaken. I was pleased to hear the evidence of Mr Spangler when he indicated he considered such an approach to be "quite reasonable" and was "more than happy to propose" it to Council. Coincidentally, Mr Spangler put a proposal to Council during its meeting held on 23 September 2014. During the course of closing submissions, I received into evidence a motion that was passed at that meeting in the following terms (exhibit 9):

"**16.1 Coronial Inquest**

Moved: Alderman Bunker

Seconded: Alderman Byrne

THAT Council receives the verbal brief given by the Director Technical Services on the Coronial Inquest currently underway into the drowning death of Richard Baird on Sunday 19th January 2014 at a drain in Gray and that the following be established and implemented prior to the commencement of the 2014/15 wet season utilising existing resources:-

- A register of all secured drains be established and maintained;
- All drains on the register be inspected specifically and regularly not less than twice a year (including once during the wet season) to review the integrity of the drain, its cover and that of all bolts and other fixings securing it;
- The results of each such inspection be recorded;
- Any maintenance and repairs undertaken be recorded and checked for satisfactory workmanship.

CARRIED UNANIMOUSLY"

66. As indicated, it is extremely pleasing to see Council taking such a proactive approach, however I do consider that the inspections need to be carried out more than twice per year and I will make a recommendation to this effect.

67. I also note that in terms of the danger signs prepared by Council that it was suggested on behalf of Richard's family that there be a telephone number placed upon such signs to enable members of the public to make contact about any damage that they discover to any drains. I was pleased to hear this suggestion accepted on behalf of the Council and I will make a recommendation accordingly.

68. Request was also made on behalf of the family that Council consider the following:

68.1 An inspection of all drains to ensure that the state of their maintenance is fit for purpose;

68.2 That drains placed on the register be marked with an identifying number to enable easy reporting to Council by members of the public; and

68.3 Consideration is made by Council to the use of tamper proof or chemset bolts to secure the drains.

69. I note that the Council has indicated that they are willing to consider these requests by the family and given that indication I simply encourage the Council to continue with their proactive approach.

Formal Findings

70. On the basis of the tendered material and oral evidence given at this inquest, I am able to make the following formal findings:

i. The identity of the deceased was Richard John Obrey Baird who was born on 11 July 2005 in Darwin in the Northern Territory of Australia.

ii. The time and place of death was at approximately 5.36pm on Monday 20 January 2014 at the Royal Darwin Hospital.

iii. The cause of death was hypoxic brain injury and multi-organ failure from drowning.

iv. Particulars required to register the death:

a. The deceased's full name was Richard John Obrey Baird.

b. The date and place of death was 20 January 2014 at the Royal Darwin Hospital.

c. The deceased was male born on 11 July 2005 and was 8 years of age at the time of his death.

d. The deceased was of Aboriginal descent.

e. The cause of death was hypoxic brain injury and multi-organ failure from drowning.

f. The cause of death was reported to the Coroner.

g. The cause of death was confirmed by ICU Director, Dr Dianne Stephens, after an autopsy was deemed unnecessary.

h. The deceased's mother was Alison Gadayurr Wunungmurra and his father was Jason James Baird.

i. The deceased lived at 4 Noltenious Court, Gray in the Northern Territory of Australia.

Recommendations

To the City of Palmerston Council

71. I therefore recommend as follows:

71.1 City of Palmerston Council compile and maintain a register of all secured drains ("the register").

71.2 With respect to those drains listed on the register, City of Palmerston inspect those drains and the integrity of the drain, any fixed metal,

bolts and other fixings securing the said drain on a regular basis at least:

71.2.1 Once prior to the commencement of the wet season each and every year;

71.2.2 Once during the course of wet season each and every year; and

71.2.3 Once at the conclusion of the wet season each and every year.

71.3 City of Palmerston Council ensure that all danger signs installed by the Council in relation to any pipes and drains have a 24 hour contact number placed upon the sign.

Dated this 14th day of October 2014

_____

GREG CAVANAGH
TERRITORY CORONER