CITATION: *Inquest into the death of Lado Lazorous* [2012] NTMC 010

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0061/2011
DELIVERED ON:	20 April 2012
DELIVERED AT:	Darwin
HEARING DATE(s):	28 and 29 March 2012
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Accidental death by drowning, Public Aquatic recreational area, Supervision and management thereof.**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman

Judgment category classification:	B
Judgement ID number:	[2012] NTMC 010
Number of paragraphs:	86
Number of pages:	31

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

No. D0061/2011

In the matter of an Inquest into the death of

LADO LAZOROUS
ON 1 MAY 2011
AT LAKE LEANYER RECREATION PARK,
KARAMA IN THE NORTHERN
TERRITORY OF AUSTRALIA

FINDINGS

Mr Greg Cavanagh SM

Introduction

1. Lado Lazorous ("the deceased") was a male born on 26 June 2006 in Darwin, in the Northern Territory of Australia. He was of Sudanese descent. On 1 May 2011 at approximately 4.30pm, the deceased was found floating face down in the main pool area of the Lake Leanyer Recreation Park ("the Park"). The deceased was retrieved from the main pool, at which point life guards on duty began cardiopulmonary resuscitation ("CPR") until St John Ambulance ("SJA") officers arrived. The deceased was taken by ambulance to the Royal Darwin Hospital ("RDH"), but despite continued attempts to save his life, he was declared deceased at 5.27pm. He was four years and 11 months of age at the time of his death.

2. This death was reportable to me pursuant to s12 of the *Coroners Act* ("the Act") because it was unexpected and unnatural and appeared to have resulted from an accident or injury. Tragically, it is also the third death in the man-made lake ("the Lake") at the Park. As a result I decided to hold a public inquest into the death in accordance with my powers under s.15(2) of the Act.

3. Pursuant to s34 of the Act, I am required to make the following findings if possible:

"(1) A Coroner investigating:

a. A death shall, if possible, find:

(i) The identity of the deceased person.

(ii) The time and place of death.

(iii) The cause of death.

(iv) Particulars required to register the death under the *Births Deaths and Marriages Registration Act*".

4. Section 34(2) of the Act operates to extend my function such 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"

5. Counsel assisting me at this inquest was Ms Jodi Truman. No other person or party formally appeared in this matter although lawyers for the Young Men's Christian Association ("YMCA") and the Northern Territory

Department of Natural Resources, Environment, the Arts and Sport ("NRETAS") respectively were present throughout proceedings. I also note that Ms Jackline Sube, the mother of the deceased, and Mr Stephen Umbasa, his father, were in attendance at the inquest. I thank them for the respect they showed to me during the course of this inquest. I have read all the documents tendered in evidence before me and it is clear that the passing of the deceased is something that has caused his family immense sorrow and grief.

6. Seven (7) witnesses were called to give evidence at the inquest. Those persons were:

   a. Detective Senior Constable Tanja Ward, the officer in charge of the coronial investigation;

   b. Mr Brent Carter, a life guard on duty at the Lake on the relevant day;

   c. Mr Jacob Sheldon, a life guard and employed manager of the Lake, also on duty that day;

   d. Ms Emma Young, a life guard and employed duty manager of the Lake, also on duty that day;

   e. Ms Annette ("Floss") Roberts, Executive Director of the Royal Life Saving Society NT Branch ("RLSSNT");

   f. Mr Caleb Johnston, who was previously employed as the Community Recreation Manager for the YMCA of the Top End at the time of this death;

   g. Mr Graham Phelps, Executive Director of the Parks and Wildlife Division of NRETAS.

7. A brief of evidence containing statements from family members, other users of the Lake on that day, life guards, medical staff, SJA personnel, and

police, together with numerous other reports, photographs, and police documentation was tendered at the inquest (exhibit 1). The deceased's medical file held with RDH was also tendered in evidence (exhibit 2). 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 would like to thank Detective Senior Constable Tanja Ward for her investigation which was of this standard.

Circumstances Surrounding the Death

Background of Deceased

8. The deceased was the youngest child to Jackline Sube and Stephen Umbasa. He was born in Darwin in the Northern Territory and lived with his mother, father, older brother (Latio) and older sister (Kani) at their home in Karama. The family had arrived in Australia on 24 December 2004. The deceased attended at the Karama Child Care Centre and Karama Primary School. By all reports he was a happy, healthy child who enjoyed activities commensurate with his age. I received evidence that he was a lovely little boy who loved watching "Toy Story" and "Ben 10" cartoons. He had attended at the Lake on several previous occasions with his family but he could not swim.

Background of Lake Leanyer Recreation Park

9. Lake Leanyer Recreation Park ("the Park") is adjacent to Vanderlin Drive, Leanyer, close to the suburbs of Leanyer, Karama and Malak. The Park has within it a man-made lake ("the Lake") which was built by the Northern Territory Department of Transport and Works. It was completed in November 1994.

10. The Park itself is 4.56 hectares and the Lake is 211 metres in circumference, being approximately 120 metres long and 40 metres wide. I received evidence from police that their measurements of the Lake show it to be 1.32

metres at its deepest point (being 20 steps into the Lake). The Lake is surrounded by grassed park land and is equipped with shade structures, barbecues, a "wet play" area and slides. It is a well-known and very popular site in the northern suburbs for family outings.

11. The Park (including the Lake) is owned by the Northern Territory of Australia and funded by the Northern Territory Government. The management of the Lake, and the grounds, was vested initially in the Northern Territory Parks and Wildlife Commission ("the Commission"). The Commission then became part of the Department of Infrastructure, Planning and Environment. Since that time the Commission has become a division of the Department of Natural Resources, Environment, the Arts and Sport ("NRETAS"). NRETAS is therefore now the government agency with overarching responsibility for the Park and Lake.

12. I received evidence that on 15 November 2010, following a formal tender process; the YMCA took control of management operations at the Lake. This occurred as it was considered by the Commission that engagement of a management body with specific expertise in water based recreation facility operations would improve the management of the Lake. I heard evidence that the YMCA was chosen as it had a demonstrated capacity to successfully undertake the safe management of such facilities as evidenced by their management of the Palmerston Aquatic and Lifestyle Centre.

13. I received evidence pursuant to a statement received from Mr Graham Phelps (Executive Director of the Parks and Wildlife Division of NRETAS) that:

> "… under the management agreement between NRETAS (on behalf of the Northern Territory) and YMCA, the YMCA is responsible for all facets of the day to day management of the facility including, among other things:
>
> (a) Staffing the facility;

(b) Cleaning, maintaining and conducting small repairs of the Lake Leanyer grounds and equipment, including the swimming pools;

(c) Supervising patrons, including by way of lifeguard services and providing security as necessary;

(d) Managing the water facilities, skate park and ancillary facilities such as the kiosk."

14. I also note that Mr Phelps stated that under the agreement:

> "NRETAS is responsible for funding repairs, refurbishment and new equipment and facilities with a value of more than $1,000".

Mr Phelps confirmed these details in his oral evidence.

15. For complete clarification, Mr Phelps also noted that as at 1 May 2011, the Parks and Wildlife division of NRETAS was responsible for overseeing the YMCA's management of the Lake, however in July 2011 this role was transferred to the Sport, Venues and Indigenous Development division of NRETAS and that is where it remains as at the date of this inquest.

Previous deaths and inquest findings

16. As noted previously, there have been two earlier deaths at the Lake about which there have been coronial investigations, namely:

16.1 Death of Telvyn Paul McKenzie on 3 January 2001; and

16.2 Death of Hayley Lillian Rose McCurry-Parriman on 14 October 2001.

17. In relation to the latter death, I determined to conduct a public inquest and handed down findings on 1 May 2002. As a result of that inquest I found that Lake Leanyer was:

> "a dangerous and unsafe recreational venue for young children".

18. As a result, I made a number of recommendations which (relevant to this inquest) can be summarised as follows:

18.1 The bounds of the park to be properly fenced with self-closing gates, akin to the type of fencing found at public suburban swimming pools;

18.2 The parts of the lake on the perimeter of the deeper water should be separately fenced off so that small children could not wander into such areas;

18.3 The facilities should be altered to enclose all features and amenities specially designed for younger children into a specified small area. In this regard I highlighted the area known as "The Cascades";

18.4 The need for more effective signage including greater use of pictorial signs, simplification of signs and better highlighting of the more important messages on the signs;

18.5 The appointment of suitably qualified staff on hand to provide proper help in the situation of an emergency;

18.6 The removal of the underwater ledge and 45˚ slope coming away from this ledge; located only metres from a shallow sandy area used by toddlers, and its replacement by a gently-sloping bed, constructed of material, which would not tend to slip;

18.7 The improvement of water visibility at the Lake to make it sufficiently clear for those using it to see the bottom; and

18.8 The formation and operation of a Water Safety Council.

19. I received evidence during the course of this inquest as to the changes made following these recommendations. In particular I received evidence from Mr Graham Phelps, as to the implementation of the recommendations. That

evidence revealed that in 2002 the Lake was upgraded and underwent significant redevelopment.

20. This resulted in the main pool area being completely rebuilt to remove the risks identified relating to fencing and gates. In addition signage was installed to Australian Standards and swimming areas were isolated. Further, staffing and management practices were upgraded to meet Royal Australian Lifesaving Society of Australia ("RLSSA") standards and an Operations Manual was developed in consultation with the RLSSA. A copy of this manual was included in the brief of evidence tendered before me as part of folio 26 of exhibit 1.

21. In terms of the recommendations outlined above, I note that I received evidence that the following was undertaken to address my recommendations:

    21.1 Although the boundary of the park was not fenced with self-closing gates, there was a combination of pool and cyclone mesh fencing. In addition, a pool standard fence with self-closing gates surrounded the swimming areas and there was an internal fence between the main car park and the skate park area. Security guards also patrolled the perimeters after hours;

    21.2 During the course of the redevelopment, the Lake was redesigned to remove deep water areas immediately along the edges, with the pool base redesigned to taper off into deeper water further into the middle. This was intended to do away with the need to fence off deeper edge waters. In addition, the area known as "The Cascades" became supervised by lifeguards working within the fenced wet areas.

    21.3 Signs were also placed at the self-closing gates indicating that children under 10 years of age and older non-swimmers were to be actively managed by parents/guardians (at least 16 years of age), with such supervisors staying within a reaching distance of no more

than 1 metre from swimmers. Lifeguards were also tasked to actively enforce these rules within the wet areas. Other various signs (including sandwich boards) outlining what was required in the enclosed wet area were placed around specific vantage points around the park.

21.4 A core of fully trained, full time lifeguards of approximately five were employed and a casual group of approximately 20 other lifeguards ranging in training skills.

21.5 The underwater ledge was completely removed during the course of the redevelopment of the Lake with shallow edges surrounding the whole perimeter of the water body and very gently slopes into the centre of the Lake where the maximum water depth is 1.2 metres. Although I do pause to note (as previously stated) that police recorded the deepest point as being 1.32 metres some 20 steps into the Lake.

21.6 Management practice was introduced at the Lake to close off part of the swimming area if lifeguards were unable to see the bottom. A raised lifeguard platform was also installed in the swimming area. Daily water quality tests were also introduced to maintain the water in as clear a state as possible.

21.7 The Water Safety Advisory Council was established and has been operational since 2002. Both Kidsafe and the RLSSA (NT) are members.

22. Importantly, and frankly, Mr Phelps also noted that there were two (2) "near drownings" in 2009 and as a result, an independent review was requested to once again assess the safety practices and processes at the Lake in terms of visitor numbers in pools and lifeguard ratios. I pause to note here that I

consider this to have been a very responsible and proactive approach taken by Parks and Wildlife.

23. This request for review resulted in RLSSA conducting an Aquatic Facility Safety Assessment in November 2009 for the Lake. This resulted in a report being prepared dated 5 November 2009 that included a Safety Improvement Plan within it. This report was also included at folio 22 of exhibit 1.

24. I received evidence from Mr Phelps that following receipt of that assessment and plan, improvements were made, one of which (particularly relevant to the circumstances of this death) was the installation of a higher observation platform to improve lifeguards' visibility of the swimming area. I will return to this issue later in these reasons.

25. As stated previously, thereafter responsibility for management operations at the Lake was transferred to the YMCA on 15 November 2010. Mr Phelps gave evidence before me concerning the reasons for the management of the Lake being outsourced (tp.66.7):

> "We believed that the facility would benefit by being run by an organisation who specialises in running water parks and the park to that point was run by the Parks and Wildlife Service of the department. I think, I would have to say, but I think quite well, but our core business, the work that we normally do is not associated with running swimming pool, water park areas and we believe that one of the benefits of outsourcing the management would be to put it in the hands of a body who's, you know, one of their prime functions is the running of such facilities".

<u>This inquest</u>

26. At the commencement of this inquest, Counsel Assisting indicated that she considered there were five general areas requiring particular consideration during the course of this inquest, namely:

26.1 The nature of the supervision provided by the adults who accompanied the deceased to the Lake on 1 May 2011;

26.2 The ease of access by children to the main pool area at the Lake;

26.3 The nature of the supervision provided by the YMCA in relation to patrons, including the deceased, at the Lake;

26.4 The appropriateness of the response by YMCA and NRETAS to the death of the deceased and reviewing the facilities at the Lake;

26.5 Whether further changes need to occur at the Lake given the death of the deceased following the redevelopment in 2006.

27. I considered these issues throughout the inquest and will address these matters during the course of these findings.

Events on 1 May 2011

28. At about 3.00pm on Sunday 1 May 2011 the deceased attended the Lake in the company of the following persons:

28.1 His mother, Jackline;

28.2 His older brother, who was 11 years of age at the time;

28.3 His older sister, who was six years of age at the time;

28.4 Four other adult female family friends;

28.5 Seven other children.

29. As identified above, by the account of the deceased's mother there were perhaps 10 children (including the deceased) and five adult females.

30. Several life guard staff who were on duty on 1 May 2011 gave evidence before me. The remainder who were on duty that day provided statements to the police shortly after these events, along with several members of the public who had been at the Lake on that day. It is apparent from the

material that the children in the group, more likely than not including the deceased, had come to the attention of life guard staff on duty that day.

31. I note that it is arguable that it appears it may have been assumed on this day that any child of African appearance was related to this group, however I do note that each of the lifeguards who gave oral evidence before me stated clearly that they recalled interaction with a group of children of African appearance and that on some of these occasions they recall that the deceased was part of the group. Given the close involvement that these lifeguards subsequently had with the deceased in performing CPR upon him, I find it more likely than not that children, including the deceased, came to the attention of life guards on this day. I also find it more likely than not that the children, including the deceased, came to the attention of lifeguards due to their attempts to enter the main pool without adult supervision.

32. It appears from the evidence that the children, including the deceased, were spoken to on possibly three (3) occasions in different areas of the Lake, including the wet play area and near the pool. It appears that all lifeguards who had noticed the children on that day were concerned about a lack of parental or adult supervision of the children.

33. Based on the evidence before me there were at least five (5) life guards on duty on 1 May 2011. I received evidence that the life guards rotate throughout the park at various posts including:

    33.1 The top of the slide area;

    33.2 The bottom of the slide area; and

    33.3 The main pool area.

34. The main pool area usually has two (2) life guards on duty depending on the number of persons using the main pool. I heard evidence that the minimum standard is that there is to be one (1) life guard for every 100 persons. The

evidence before me is that shortly prior to the time that the deceased was discovered there were two (2) life guards in the main pool area, and approximately 84 persons using the main pool.

35. As stated earlier, it appears that the group of children that the deceased was in company with came into contact with the lifeguards on duty at the Lake on 1 May 2011. I also make this finding, not just based on the evidence of the lifeguards themselves, but also on the statements of other visitors who attended at the Lake that day and noticed the group of children.

36. It appears that although the children were all quite young in age, with the deceased most likely the youngest in the group, the five (5) adults that took them (including the deceased's mother) to the Lake that day did not remain with them at all times. The statement of the deceased's mother, Ms Sube, sets out that she sat in a shaded area near the tables and chairs outside of the main pool area. This area was depicted in evidence before me by Counsel Assisting.

37. I received a statement into evidence from another visitor to the Lake that day, namely Ms Cayley, who was at the Lake that day with her husband and children. Ms Cayley estimated that the distance from the main pool gate to where the adults were sitting was:

> "… at least a good 100 metres away".

38. Further, Ms Cayley observed:

> "From where they (i.e. the adults of the deceased's group) were sitting they wouldn't have had a clear view of the main pool area because the undercover seating area and water play station would have been in the way".

My observation of the area depicted on the map also confirms this opinion.

39. In addition, Ms Sube set out in her statement to the police:

> "On that day I did not go to the big pool area with Lado or my other kids. On other days Latio has been in the big pool area, but not Lado. I have not been in the big pool area before".

40. I therefore consider it clear on the evidence that the adults in the group that took the deceased and the other children to the Lake on that day did not remain in close proximity of the children and that there were occasions when the children were left unsupervised by the adults in their group and therefore were left able to roam around the Park, including the Lake, without adult supervision.

41. On this day, Mr Jacob Sheldon (who is the Park Manager at the Lake) was performing duties as life guard. Mr Sheldon gave evidence that he recalled seeing a group of children who appeared to be of African descent and having interaction with them. Mr Sheldon recalled the children attempting to gain access to the pool and of having to advise them to get a parent (tp.41.5):

> "It was a long time ago but I do remember children, the African children trying to gain access to the pool and having a conversation with the older children saying that – I think the oldest one was 11 or something he was saying. Saying that's fine but you need to go and get a parent if you want to let the rest in".

42. I received evidence that at the Lake, children over 10 years of age can enter the pool area unsupervised; however children under 10 years of age must be supervised by a parent/guardian or person over the age of 16 years. I note that this rule is in fact set out on a number of signs located around the Lake area (see exhibit 6). The rule is also contained in the Operations Manual for the Park (see folio 26 of exhibit 1). I pause to note that this rule is based on the RLSSA standard safety guidelines that were also tendered into evidence (see folio 22 of exhibit 1).

43. Ms Emma Young was also on duty as a lifeguard at the Lake on 1 May 2011. Ms Young also recalled seeing a group of African children, including the deceased, and interacting with them about access to the main pool area (tp.21.7):

> "During the day from my knowledge a couple of the kids in question were in the pool at the time without supervision and that they'd been asked to leave and to grab mum or whoever they're with and come back and make sure that they're being supervised. And that happened I think twice, it happened before".

44. Mr Brent Carter was also on duty as a lifeguard at the Lake on 1 May 2011. Mr Carter gave evidence that at around 4.30pm he was located performing duties near the main entrance gate of the pool area. In terms of a lifeguard being "on the gate", Mr Carter gave the following evidence (tp.28.6):

> "CORONER: On that day was there a lifeguard at the entry point to the pool?---Yes.
>
> And is that a usual thing?---If there was one lifeguard on the – in the pool, it can be difficult for the lifeguard to see the deep end because it's on the other end. So there isn't always a lifeguard on the gate. But if there are two lifeguards on, then there's someone generally at the gate. The lifeguard on the gate is tasked to watch the shallow end of the pool, keep an eye on the cascades and keep an eye on the gate also".

45. Mr Carter stated that around 4.30pm he saw "a lady" carrying a child out of the water. When he realised something was wrong with the child, Mr Carter immediately called a "major emergency" over the radio and used the RLSSA hand signal to indicate a major emergency in case any of his fellow lifeguards did not hear the call on the radio correctly.

46. Mr Carter gave evidence that the children had gained entry into the main pool area as they were seen in the company of an adult female also of African appearance who was sitting down inside the perimeter of the pool and the deceased appeared to be "with" that lady. Mr Carter stated (tp.29.2):

> "And when they came back in they came in with an adult, which is why we let them back in".

47. In relation to this adult female, I note that the older brother of the deceased provided a statement to the police on 5 June 2011. This statement formed part of folio 12 of exhibit 1. In that statement the deceased's brother states:

> "I remember Mohamed's mum going inside the pool area. She sat on the bench. She did not go inside the pool. Mohamed's mum went inside the pool area because she wanted to; none of the lifeguards told her to go inside the pool area. She just wanted to go inside the pool area".

48. I take the reference to "Mohamed" as being a reference to another child who was part of the group that went to the Lake with the deceased on this day. I note that this child also provided a statement to the police on 3 June 2011 (see exhibit 1). In that statement the child states:

> "Earlier on in the day I saw the little boy in the water with the other African children, but this time they were not near him. I did not see how the little boy entered the pool area and I did not see how long he was in the water for before we found out that he was unconscious".

49. I therefore find that at some stage, one of the adult women in the group that took the children (including the deceased) to the Lake on 1 May 2011 did in fact enter the main pool area and it appears more likely than not that this is how the deceased was able to gain entry into the main pool area.

50. Based upon the evidence it is clear that as soon as the deceased was discovered, an emergency plan was activated by lifeguard staff at the Lake. I note that at no point during the coronial investigation, or at the hearing before me, was any issue raised as to the reaction by staff to the emergency and I therefore do not intend to address this issue further. I consider the response by staff to have been appropriate.

51. When the deceased was discovered; he was floating face down in the main pool area. He was removed from the water and CPR commenced. It was noted that his eyes were open and he had obstructions (variously described as vomit or regurgitated food) in his mouth. Attempts were made to clear

this away. Whilst CPR was performed, the lifeguards described that water kept coming from the deceased's mouth whenever attempts were made to do the breaths. The deceased's jaw was also noted to be "really firm" or "locked". Despite continued CPR by lifeguard staff until the St John Ambulance arrived, there was no response at any time from the deceased and no signs of life.

52. During the course of the inquest, I became aware that there was a concern by the family about the deceased either vomiting or regurgitating food during the course of CPR being performed. The concern of the family being that this may have been an indicator that the deceased was still alive. In this regard, I note that Mr Sheldon gave evidence that based on his experience and qualifications as a life guard, he was trained that there was a difference between "regurgitation" and "involuntary fluids". Mr Sheldon gave evidence as follows (tp.35.10):

> "So when we do our courses we're always told the difference between involuntary – I can't think of the exact words but the difference between regurgitation and involuntary fluids coming out. So generally if we notice any regurgitation we put them straight onto their side, check for signs of life and then continue with – if nothing was happening. By our view there was no signs of life that whole time we were conducting CPR".

53. I note that Mr Carter stated in his evidence that he did in fact place the deceased on his side during the course of administering CPR. I also note that each one of the life guards that gave evidence before me stated clearly that at no stage did they see any signs of life from the deceased in all the time that they were with him. I find that the fluids coming from the deceased during the course of CPR were not an indication that the deceased was alive at that time.

54. Upon arrival at the Lake, SJA staff further suctioned the airway of the deceased and also found vomit and water still coming from the deceased's mouth and airway passage. Adrenaline was administered; however the

deceased's heart rhythm was found to be aystolic throughout, i.e. there was no electrical activity taking place within the heart. Despite several administrations of adrenaline, electrical activity in the heard did not recommence.

55. The deceased was subsequently placed in the ambulance to travel to the hospital. En route attempts were made to place an endotracheal tube into the deceased's airway but this was unsuccessful as water and stomach contents kept coming up with every compression. According to the SJA Case Card, the ambulance received the emergency call at 4.35pm. They arrived at the scene at 4.39pm and were with the deceased at that time. They departed the Lake at 4.53pm and arrived at the hospital at 5.02pm. Their response was exemplary.

56. The Royal Darwin Hospital records also record the deceased arriving by ambulance at 5.02pm. The Clinical Progress notes state that the deceased did not respond to intubation, adrenaline or warm blankets. The deceased's pupils were recorded as "fixed and dilated" and his lungs were "water logged". The decision to cease resuscitation was made and the child was declared deceased at 5.27pm.

57. An autopsy was conducted by Dr Terence Sinton on 3 May 2011 which recorded the cause of death to be "drowning". A copy of Dr Sinton's report was tendered into evidence before me as part of exhibit 1. At autopsy, the only significant finding was of frothy fluid in the upper airways, consistent with drowning. As previously recorded, I find that the deceased drowned.

Events post 1 May 2011

58. Following this death, the YMCA conducted its own Critical Incident Review ("YMCA review"), a copy of which was tendered before me as part of exhibit 1. I consider this to have been a very responsible and proactive approach taken by the YMCA. I consider it important that organisations

always take an approach of attempting to consider their own systems and making improvements/changes in an attempt to avoid a recurrence of incidents, rather than simply wait for a coronial inquest and recommendations to flow.

59. That YMCA review noted (at page five) that following the incident certain action had already been taken at the Lake:

59.1 Security guards had been sub-contracted on high usage days (weekends and public holidays) at the pool entry gates to screen for appropriate adult supervision of children entering the pool area. This was also confirmed in evidence before me by the life guards who gave evidence. I note that this appeared to be considered by each of them to be a real improvement;

59.2 CCTV at the Park was repaired (this was found to have not been working on 1 May 2011 due to a direct strike by lightning some weeks prior). Although I find this would have made no difference whatsoever to the deceased's passing, it is obviously a matter that may have provided relevant evidence to this inquest. CCTV footage is an important resource for many reasons and I consider it important that this has been attended to. I also note that in this inquest, the absence of that CCTV footage has meant that the family of the deceased remain concerned as to the truth of the evidence given by the various lifeguards involved. As stated by me during the course of the inquest, because of the absence of this footage the suspicions of the bereaved family are unable to be addressed. Such facilities go a long way to alleviating people's concerns and confirming the truth of what witnesses say.

59.3 Additional speakers were installed for the public announcement ("PA") system with an automatic message system established to remind parents to supervise children at a minimum every hour.

Lifeguards can also request the message be aired immediately or as required if they identify this behaviour is occurring. I note that during the course of the evidence before me it was indicated that at the time of this death the PA system existed but it was manually operated. Again I do not consider this would have made any difference to the passing of the deceased, however I consider this a change for the better to have information announced on a regular basis reminding people of the rules at the Lake;

59.4 Half pool closure was developed to occur at times of poor visibility or during quieter periods of operations to reduce pool size. In this regard, I heard evidence from the lifeguards on duty that all attempts are made to keep the main pool area open. One witness gave evidence that he recalled an occasion where there were in fact four to five lifeguards located in the main pool area monitoring each corner of the pool at busy times and/or when visibility was poor, rather than closing the pool. I consider this an important development and again note it appears to be considered an improvement by the staff;

59.5 Extra signage in relation to parental active supervision requirements were placed around the pool fences. As previously noted I received photographs of the various signs located around the Lake. Mr Caleb Johnston identified which of these signs were pre, and which were post, the deceased drowning. I consider all of these signs to be appropriate and address the need for "active" parental supervision. I also note that the signs are not just by way of "words", but that there are also "pictures" to depict what is required. This is important considering our multi-cultural society and the number of persons who may not be able to read English. I consider that the signs that were installed post this death are an improvement and go even further in identifying the need for "active" adult supervision;

59.6 More pool keys were cut to accommodate emergency evacuation procedures;

59.7 Follow up counselling and support was provided to all staff involved.

60. As a result of the YMCA review a number of recommendations were also made (see page six):

60.1 Pool visibility to be increased. This included

60.1.1 The creation of a standard operational procedure that closes any area of poor visibility, suggestion of the use of "Area Closed" signs to be utilised for this procedure, and consideration to include a "visual" cue within the sign to further enhance the worded message.

60.1.2 In consultation with the NT Government engage an appropriate consultant to advise on pool floor colouring with a view to making it more resemble that of a regular pool floor.

60.1.3 The exploration for adding more lines to the pool floor to increase visual awareness and focal/reference points for the eye.

60.1.4 The creation of a "visibility log" for the pool floor and create procedures and operational policies in line with the "poor visibility" log, together with discussions with the NT Government about options for reduced pool hours at times of poor visibility.

60.2 A policy change in relation to active supervision by parents;

60.3 The creation of a community education program. This included:

60.3.1 Consideration to the introduction of the "AquaSafe Theory Program" for delivery by staff to local community groups;

60.3.2 Consideration to the registering with RLSSA (NT) for the introduction of the "Watch Around Water" campaign;

60.3.3 In consultation with Government and local authorities, the development of a proposal to initiate an annual awareness campaign solely targeting the importance of supervision in, on or around aquatic environments.

60.4 The development of an escalation process to provide all levels of staff with clear directional steps to communication in the event of an incident;

60.5 The development of a media/communications strategy;

60.6 Formalisation of a training schedule for new and existing staff;

60.7 Consideration to including a lifeguard rotation that includes a "walk through" of the pool at regular intervals;

60.8 Consideration to creation of a mobile first aid storage unit or temporary fixed unit housing the equipment located at the far side of the pool during operational hours;

60.9 Investigation of the possibility of "scanned lock" systems being fitted universally throughout the park to ease the flow of staff from one section to the other; and

60.10 The communication of review findings to staff.

61. I received evidence in relation to the implementation of those recommendations post review. Importantly in relation to the circumstances of this death, I received evidence that in October 2010 the entire main pool was drained and the base of the pool was cleaned. In addition, better filtration systems were put in place to improve water clarity. Further, the "soft floor matting" of the wet play area was replaced. I received evidence

that this matting had been "breaking down" and was impacting on the water quality as the water of the wet play area was shared with the main pool.

62. The lifeguards who gave evidence indicated that since the drainage of the pool and the repair of the matting, water clarity in the main pool area had "improved 100%". As a result of this it had been determined that it was no longer necessary for the engagement of an appropriate consultant to advise on pool floor colouring. I accept this evidence.

Issues raised for consideration at this inquest

63. As previously noted, at the commencement of this inquest, Counsel assisting outlined a number of issues that she suggested I may wish to consider and make comment upon, pursuant to my powers under s34(2) of the Act, and I now do so.

The nature of the supervision provided by the adults who accompanied the deceased to the Lake on 1 May 2011

64. There is evidence that there were issues surrounding the supervision of a group of young African children on 1 May 2011 by the adults that brought those children to the Lake. I have already found that this group, more likely than not, included the deceased. I note that the older brother of the deceased states in his statement to the police that his mother did not go inside the pool area at any time. The deceased's mother also records that she did not go into the pool area. I also find that one of the adult women in the group did go into the main pool area at the same time as the children (including the deceased) but it appears that she did not supervise all of the children in the required "active" manner.

65. I wish to clearly indicate, as I am concerned that my comments may be misinterpreted by those who may later read these findings, that this is NOT to say that the adults of the group (including his mother) who brought the children to the Lake are to blame for the death of the deceased. As I stated at the inquest, children can drown VERY quickly and in a VERY small

amount of water. No matter how safe you attempt to make an aquatic venue, there is always going to be an inherent danger simply because of the association of water and little children. All that can be done is to attempt as much as possible to reduce that danger.

66. I consider it is very important to make clear that it should never be the case that parents or guardians consider that by virtue of the existence of lifeguards at a facility, this means that supervision by parents or guardians no longer needs to occur.

67. I note that in several of the photographs of the signs at the Lake it is made clear that supervision of children under 10 years of age occur at all times by a person 16 years or older. This is depicted in words and symbols. The following is also stated in one of the signs:

> "While at this pool you are responsible for your child, please remember:
>
> - Lifeguards are not babysitters
> - You watch your own kids at home, when visiting a swimming centre it's exactly the same rule!
> - For children aged 0-5 be within arm's length at all times
> - For children aged 6-10 be prepared to jump in and help!"

68. This is an extremely important message. There should be no doubt in the community that whilst lifeguards are very important and essential at any public water recreation facility, they do not and should not replace parental/guardian supervision. Parents and guardians have a continuing responsibility for their children. I note that the national guidelines for supervision developed and provided for by the RLSSA under their Supervision Guidelines also provides at SU3, sections 4.1-4.3 as follows:

> "4.1 Children under 10 years should not be allowed entry unless under the active supervision of a person 16 years or older.

(Active is defined by the Concise Oxford Dictionary as: given to action, working, effective, practical, diligent).

4.2 Parents or guardians (including those persons described in Section 4.1 above) should actively supervise their charges at all times and as such should be dressed ready to take action, including unexpected entry to a pool.

4.3 Parental/guardian supervision of children is in addition to, and in no way replaces, lifeguard supervision"

69. I consider that the evidence led at this inquest reinforces the need for parental supervision as the foremost means of avoiding childhood drowning in our community.

The ease of access by children to the main pool area at the Lake

70. I note that I received evidence that as at 1 May 2011 there was a "main gate" that provided access into the pool. There was also another unlocked gate closer to the Cascades area that allowed access to the main pool, but was generally used by staff.

71. The lifeguards that gave evidence before me stated that as at the date of this death a lifeguard was generally stationed "near" the main gate area to supervise the children and ensure that the rules associated with supervision were complied with. I heard evidence that even if the lifeguard was not "on" the gate, the noise of the gate itself drew their attention to the entry of patrons into the pool and as a result they monitored such entry.

72. Whilst I accept the evidence given to me by the lifeguards was truthful, I consider that the absence of a person at the gate to monitor the entry of persons and ensure that the rules were complied with does give rise to a greater risk that a child may be able to enter without appropriate supervision, particularly on those occasion where (as they were on 1 May 2011) the pool is very busy and visibility is reduced by the sheer number of people in the pool and the surrounding glare.

73. Although I have already found that it is more likely than not that the deceased was able to gain entry because of his entry with an adult female of African descent, I do consider that it is an important improvement at the Lake that on busy days, such as weekend and public holidays, there is now a security guard employed to monitor the gate and ensure that the rules are complied with in terms of entry into the main pool. I encourage the YMCA to continue this arrangement so as to enable the lifeguards on duty to be able to concentrate on their main role of monitoring the pool area and those located within it.

74. I also note the evidence given before me as to the changing of the entry system resulting in lifeguards having a swipe key so that they are able to enter and exit the various areas of the Lake, leaving only one entrance gate for the public. I consider this a relevant improvement.

75. I have considered whether there should be a recommendation made that the security guard should be required to ensure that children under 10 years of age are accompanied by an adult on a "one on one" basis, and I decline to do so. I am aware from the evidence that the RLSSA is constantly reviewing and updating its national safety guidelines and that they appear to have determined that it is not necessary to amend their national guidelines to provide for "one on one" supervision. I was impressed by the evidence given by Ms Roberts of the RLSSA as to the work carried out by that Association and I consider that if there were a need for a ratio of that nature to be required then I would have received evidence from the RLSSA related to that fact.

The nature of the supervision provided by the YMCA in relation to patrons, including the deceased, at the Lake

76. I find that the YMCA carried out its role in supervising the patrons at the Lake, including the deceased, on 1 May 2011 in an appropriate manner and in accordance with the RLSSA Guidelines related to supervision. I note as

well that such supervision was in accordance with their own Operations Manual for the Lake. I was impressed with the level of sincerity of the lifeguards who gave evidence before me and accept that they took their role as lifeguards seriously both now, and on 1 May 2011.

77. I also consider that post this death, the supervision provided by the YMCA at the Lake has further improved and it is clear that attempts continue to ensure that the level of supervision offered by the YMCA at the Lake is appropriate and meets the needs of those who use the Lake.

78. In this regard I note that Ms Roberts, Executive Director of the RLSSA, gave evidence of her opinion as to the level of safety offered at the Lake since my findings in 2002 and since the YMCA had undertaken management at the facility (tp.48.7):

> "The facility now is operated to the highest standards possible. It is a fantastic facility where families can go free entry to have a water source that is safe, crocodile free, box jellyfish free and actually the water meeting safety standard that most of our beach water doesn't meet in the health records. It's a credit to the whole of the Northern Territory and something to be proud of. It's really difficult that – and very very sad that we've had this tragic incident. We've got the highest drowning rate per capita in Australia unfortunately and it's something as a community we're all going to have to just try and make ourselves safer around water. Having that venue where it is for the whole community to use and families, it's safety with lifeguards there and for the whole community to use is of a high standard".

79. Ms Roberts also gave evidence in relation to the management of the Lake by the YMCA and provided a copy of an assessment done by RLSSA of the Lake in 2011, post this death (this formed part of exhibit 1). Ms Roberts stated that in terms of her assessment of the management of the Lake by the YMCA (tp.47.10):

> "I conducted aquatic facility assessments across our 21-odd pools in the whole of the Northern Territory. This facility has the highest percentage around safety. So 95% compliant across the whole facility is quite amazing".

80. I also note the evidence given by Mr Phelps of NRETAS that in terms of his opinion of the management of the Lake by the YMCA:

> "We've been delighted that they're a very proficient organisation. It was a new approach for us to take and so we weren't sure how it would pan out and we've been very pleased that they – they have been extremely professional, they know what they're doing and they've been really good to work with".

The appropriateness of the response by YMCA and NRETAS to the death of the deceased and reviewing the facilities at the Lake

81. As noted earlier in these findings, I was impressed with the response given particularly by the YMCA, and to a lesser extent by NRETAS, to this death. I consider the YMCA should be commended for the proactive way in which they have approached this death and its circumstances. I also consider that NRETAS should be commended for monitoring the response undertaken by YMCA given the ultimate responsibility for the Lake rests with NRETAS.

Whether further changes need to occur at the Lake given the death of the deceased following the redevelopment in 2006

82. After having heard all of the evidence related to what I consider have been significant changes at the Lake since its redevelopment, and most particularly since this death, I do not consider it necessary that I make any recommendations in relation to further changes at the Lake.

Conclusion

83. The death of Lado Lazorous was a very sad and tragic accident; it illustrates just how very easy it is for young children to drown. At public aquatic facilities this is made all the more difficult to detect when the facility is busy with visitors, both children and adults alike. This makes it all the more important for the community as a whole to understand that around water, children require "active" supervision at all times. Even if children know the basics of swimming, they cannot be left unsupervised. Lifeguards at venues such as the Lake are just one part of the supervision that is required. They

do not, and cannot, replace supervision by a parent or guardian who is over the age of 16 years.

84. I encourage the YMCA and RLSSA in its endeavours to continue to educate the community as a whole as to the risks associated with children around water and the need for "active" supervision. The prevention of our children from drowning is obviously of benefit to us all.

85. I have no recommendations to make arising from this inquest.

Formal Findings

86. Pursuant to section 34 of the Act, on the basis of the tendered material and oral evidence received at this Inquest, I find as follows:

i. The identity of the deceased person was Lado Lazorous who was born on 26 June 2006 in Darwin, in the Northern Territory of Australia.

ii. The time and place of his death was at or about 4.30pm on 1 May 2011 at the main pool area of the Lake Leanyer Recreation Park, Karama.

iii. The cause of death was drowning.

iv. Particulars required to register the death:

a. The deceased was a male.

b. The deceased's name was Lado Lazorous.

c. The deceased was of Sudanese, African descent.

d. The death was reported to the Coroner.

e. The cause of death was confirmed by post mortem examination carried out by Dr Terence Sinton.

f. The deceased's mother was Jackline Alibino Sube and his father was Stephen Lazorous Umbasa.

g. The deceased lived at 44 Dorrigo Crescent, Karama in the Northern Territory of Australia.

h. The deceased was a child and therefore not employed at the time of his death.

Dated this 20th day of April 2012

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GREG CAVANAGH
TERRITORY CORONER