Ombudsman's Foreword

As Western Australian Ombudsman, I have an important responsibility to review certain child deaths, identify patterns and trends arising from these reviews and make recommendations about ways to prevent or reduce child deaths. Of the child death notifications received by my office since I commenced my child death review responsibility, 42 have been deaths of children by drowning.

This investigation aimed to develop an understanding of the deaths of children who died by drowning. Informed by this understanding, the investigation further aimed to examine the actions of local governments and state government departments and authorities in administering the relevant laws of the Western Australian Parliament and relevant regulations and standards. Moreover, the investigation aimed to develop an understanding of non-fatal drowning incidents involving children.

To undertake the investigation, my office conducted an extensive literature review, comprehensively considered 34 deaths of children by drowning notified to the office over a six-year investigation period, surveyed all local governments in Western Australia (to which my office received a 99 per cent response rate), selected five local governments for further investigation, collected and analysed comprehensive information regarding the number of private swimming pools in local government districts and the quality of the swimming pool barrier inspection process, engaged with the (now) Department of Mines, Industry Regulation and Safety, the Building Commissioner, the Department of Health, the (now) Department of Local Government, Sport and Cultural Industries and relevant non-government and not-for-profit organisations.

My office also collected and analysed de-identified information regarding the number of children admitted to a hospital or who attended an emergency department at a hospital following a non-fatal drowning incident. My office found that 258 children were admitted to a hospital and 2,310 children attended an emergency department at a hospital following a non-fatal drowning incident.

I have found that a range of work has been undertaken by the Department of Mines, Industry Regulation and Safety and the Building Commissioner to administer their respective responsibilities in relation to swimming pool safety. I have also found that there is important further work that should be done. This work is detailed in the findings of this report. It will be critical that this work is undertaken with strong cooperation between the Department of Mines, Industry Regulation and Safety, the Building Commissioner, local governments and other key stakeholders, including intra-agency, inter-agency and cross-sectoral arrangements – this is the most efficient and effective way to achieve positive change.

Arising from my findings, I have made 25 recommendations about ways to prevent or reduce deaths of children by drowning. I am very pleased that the Department of Mines, Industry Regulation and Safety and the Building Commissioner have agreed to these recommendations. In keeping with my commitment to Parliament to ensure Parliament is informed about the implementation of my investigations, my office will actively examine the steps taken to give effect to the recommendations and report the results of this examination to Parliament in 2018.

I note my appreciation to the Department of Mines, Industry Regulation and Safety, the Building Commissioner and local governments – their cooperation through the investigation has been particularly positive and reflects their genuine willingness to engage in review, reflection and improvement.

The death of a child by drowning is a tragedy – for a child's life lost and for the parents, families and communities that have been personally affected by the tragic death. It is my sincere hope that the investigation will, through its research and analysis and its recommendations, make a meaningful contribution to the prevention and reduction of this tragic loss of life.