

## 2 About the Investigation

### 2.1 The Western Australian Ombudsman

#### 2.1.1 The Ombudsman

The Ombudsman is an independent and impartial statutory officer who reports directly to Parliament, rather than the government of the day.

#### 2.1.2 The role of the Ombudsman

The Ombudsman has functions in relation to the investigation of state government departments, local governments and universities. These investigations may arise from complaints received by the Ombudsman, of the Ombudsman's own motion or by reference from Parliament.

The Ombudsman also has an important function to review certain child deaths and family and domestic violence fatalities as well as a range of additional functions, as set out in legislation, including inspection, monitoring, scrutiny and reporting.

#### 2.1.3 The Ombudsman's child death review function

The Ombudsman commenced the review of certain child deaths on 30 June 2009 following the passage of the *Parliamentary Commissioner Amendment Act 2009*. The Ombudsman reviews investigable child deaths. Section 19A(3) of the *Parliamentary Commissioner Act 1971* (**the Act**) defines an investigable death as follows:

An investigable death occurs if a child dies and any of the following circumstances exists –

- (a) in the 2 years before the date of the child's death, the CEO [the Interim Chief Executive Officer of Department of Communities] had received information that raised concerns about the wellbeing of the child or a child relative of the child;
- (b) in the 2 years before the date of the child's death, the CEO, under section 32(1) of the CCS Act [Children and Community Services Act 2004], had determined that action should be taken to safeguard or promote the wellbeing of the child or a child relative of the child;
- (c) in the 2 years before the date of the child's death, any of the actions listed in section 32(1) of the CCS Act was done in respect of the child or a child relative of the child;
- (d) protection proceedings are pending in respect of the child or a child relative of the child;
- (e) the child or a child relative of the child is in the CEO's care.

For these investigable deaths, the Ombudsman's functions are outlined in section 19B(3) of the Act, as follows:

- (a) to review the circumstances in which and why the deaths occurred;
- (b) to identify any patterns or trends in relation to the deaths;
- (c) to make recommendations to any department or authority about ways to prevent or reduce investigable deaths.

The Department of Communities (**Communities**) receives information from the Coroner on reportable deaths of children and notifies the Ombudsman of these deaths. The notification provides the Ombudsman with a copy of the information provided to Communities by the Coroner about the circumstances of the child's death together with a summary outlining the past involvement of Communities with the child.

The Ombudsman assesses all child death notifications received to determine if the death is, or is not, an investigable death. If the death is an investigable death, it must be reviewed. If the death is a non-investigable death, it can be reviewed. The extent of a review depends on a number of factors, including the circumstances surrounding the child's death and the level of involvement of Communities or other public authorities in the child's life. Confidentiality of the child, family members and other persons involved with the case is strictly observed.

The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

## 2.2 About the Investigation

### 2.2.1 Rationale

Through the review of the circumstances in which, and why, child deaths occurred, the Ombudsman identified a pattern of cases in which children appeared to have died by drowning. In accordance with the Ombudsman's child death review function, children are defined as those under 18 years of age. The Ombudsman decided to undertake an investigation into these deaths with a view to determining whether it may be appropriate to make recommendations to any local government or state government department or authority about ways to prevent or reduce deaths of children by drowning (**the Investigation**).

## 2.2.2 Definition of drowning

Following consultation with international experts in clinical medicine, prevention and rescue at the World Congress on Drowning in 2002, the World Health Organization (**WHO**) formulated the following definition of drowning and adopted the definition in 2005:

Drowning is the process of experiencing respiratory impairment from submersion/immersion in liquid.<sup>28</sup>

The international consensus at the World Congress on Drowning was that this 'new definition should include both cases of fatal and non-fatal drowning' and that '[d]rowning outcomes should be classified as: death, morbidity, and no morbidity.'<sup>29</sup>

Accordingly, as part of the Investigation, the office of the Ombudsman (**the Office**) has analysed information about children who died by drowning and information about children who were admitted to a hospital or attended an emergency department at a hospital following a non-fatal drowning incident.

## 2.2.3 Aims and objectives

### 2.2.3.1 Aims

The Investigation had two aims. First, the Investigation aimed to develop an understanding of the deaths of children who died by drowning and an understanding about the children who were admitted to a hospital or attended an emergency department at a hospital following a non-fatal drowning incident.

Second, informed by this understanding, the Investigation 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, more particularly, the *Building Act 2011*, the *Building Regulations 2012* and the *Australian Standard 1926.1 – 1993 Swimming Pool Safety Part 1: Fencing for swimming pools (AS 1926.1-1993)*, which relevantly regulated the inspection of swimming pool barriers at the time of the Investigation. Where relevant, the Investigation took into account the amendments to the *Building Regulations 2012* that took effect from 1 May 2016 and 9 August 2017, and the updated *Australian Standard Swimming Pool Safety Part 1: – Safety Barriers for Swimming Pools (AS 1926.1-2012)*.

---

<sup>28</sup> van Beeck, E, Branche, C, Szpilman, D, Modell, J, and Bierens, J. 'A new definition of drowning: towards documentation and prevention of a global public health problem.' *Bulletin of the World Health Organization*. Volume 83, Number 11, November 2005, p. 853, viewed 19 December 2016, <<http://www.who.int/bulletin/volumes/83/11/vanbeeck1105abstract/en/>>.

<sup>29</sup> van Beeck, E, Branche, C, Szpilman, D, Modell, J, and Bierens, J. 'A new definition of drowning: towards documentation and prevention of a global public health problem.' *Bulletin of the World Health Organization*. Volume 83, Number 11, November 2005, p. 853, viewed 19 December 2016, <<http://www.who.int/bulletin/volumes/83/11/vanbeeck1105abstract/en/>>.

### 2.2.3.2 Objectives

The objectives of the Investigation were to:

- provide a detailed, de-identified profile of children who died by drowning or were admitted to a hospital or attended an emergency department at a hospital, following a non-fatal drowning incident in Western Australia,<sup>30</sup> over a six-year period from 1 July 2009 to 30 June 2015 (**the six-year investigation period**);
- provide a detailed understanding of the circumstances of the deaths of children who died by drowning, and the circumstances of the admission of children to a hospital or attendance at an emergency department at a hospital by children following a non-fatal drowning incident in Western Australia, in the six-year investigation period;
- identify patterns and trends among contributory factors to fatal and non-fatal drowning incidents involving children in Western Australia;
- taking into account the findings regarding the patterns and trends among contributory factors, analyse how effectively local governments and state government departments and authorities were implementing the requirements of the *Building Act 2011*, the *Building Regulations 2012* and AS 1926.1-1993, with respect to the inspection of swimming pool barriers, to prevent or reduce deaths of children by drowning; and
- based on this analysis, determine whether it may be appropriate to make recommendations to any local government or state government department and authority to prevent or reduce deaths of children by drowning.

### 2.2.4 Methodology

To undertake the Investigation, the Office:

- conducted a literature review;
- engaged with the local governments and state government departments and authorities that were the subject of the Investigation;
- consulted with non-government and not-for-profit organisations and the Coroner's Court of Western Australia;
- collected and analysed qualitative and quantitative information;
- developed a preliminary view and provided it to relevant local governments and state government departments and authorities for their consideration and response; and
- developed a final view including findings and recommendations.

#### 2.2.4.1 Literature review

The Office conducted a review of relevant state, national and international literature regarding drowning generally, as well as literature specific to the inspection of private swimming pools by local governments. Throughout this report, the information drawn from this review is referred to as **the research literature**.

---

<sup>30</sup> Where a child has been included as being admitted to a hospital following a non-fatal drowning incident, they have not also been included as attending an emergency department at a hospital, even if this also occurred. Similarly, where a child has been included as having died by drowning, they have not also been included as being admitted to a hospital or attending an emergency department at a hospital, even if this also occurred. This approach was chosen so as to focus the Office's analysis on the most serious consequence of the fatal or non-fatal drowning incident.

#### 2.2.4.2 *Engagement*

The Office engaged with the following local governments and state government departments and authorities that were the subject of the Investigation:

- all local governments in Western Australia;
- the (then) Department of Commerce (functions relevant to the Investigation now undertaken by the Department of Mines, Industry Regulation and Safety);
- the Department of Health; and
- the (then) Department of Local Government and Communities (functions relevant to the Investigation now undertaken by the Department of Local Government, Sport and Cultural Industries).

#### 2.2.4.3 *Consultation*

The Office consulted with the following non-government and not-for-profit organisations:

- Kidsafe WA;
- The (then) Local Government Managers Australia – WA, now Local Government Professionals;
- Master Builders Association of Western Australia;
- Royal Australasian College of Physicians;
- Royal Life Saving Society Western Australia Inc;
- St John Ambulance Western Australia Ltd;
- Swimming Pool and Spa Association of Western Australia;
- Telethon Kids Institute;
- Western Australian Local Government Association; and
- Western Australian Swimming Association Inc.

The Office also consulted with the Coroner's Court of Western Australia.

#### 2.2.4.4 *Information collection and analysis*

##### ***Children whose deaths by drowning were notified to the Ombudsman***

During the six-year investigation period, the (then) Department for Child Protection and Family Support (now Communities) notified the Ombudsman regarding children who died in the circumstance of drowning. For the Investigation, the Office examined the deaths of 34 children who had died by drowning. In this report, these children are referred to as **the 34 children who died by drowning**.

The 34 children who died by drowning do not include children whose deaths occurred in the circumstance of drowning but the Coroner found the cause of death to involve suicide, homicide or a car accident. The 34 children who died by drowning also do not include the eight children who died in the Suspected Illegal Entry Vessel 221 boat tragedy off the coast of Christmas Island in December 2010.

For each of the 34 children who died by drowning, the Office received information from local governments, state government departments and authorities and was provided information by the Coroner's Court of Western Australia.

### ***Children who were admitted to a hospital or who attended an emergency department at a hospital as a result of a non-fatal drowning incident***

To more fully understand patterns and trends in drowning, the Office collected and analysed information regarding all children who were admitted to a hospital or who attended an emergency department at a hospital following a non-fatal drowning incident during the six-year investigation period.

#### ***Private swimming pools and their inspection***

In order to further examine the responsibilities of local governments, the Office also collected information by:

- surveying all Western Australian local governments regarding the number of private swimming pools within their local government district and their inspection of these private swimming pools;
- selecting five local governments (**the five selected local governments**) and obtaining from each of them records regarding the inspection of 100 randomly selected private swimming pools, including the inspection history and the most recent inspection form; and
- undertaking structured interviews with officers at the five selected local governments.

The Office analysed the information collected using qualitative and quantitative analytical methods that led to draft findings. The Office engaged with the local governments and state government departments and authorities that were the subject of the Investigation, and consulted with stakeholders regarding the results of this analysis and draft findings.

##### *2.2.4.5 Preliminary view*

The Office provided the local governments and state government departments and authorities with the relevant parts of our draft findings and draft recommendations for their consideration and response.

##### *2.2.4.6 Final view*

Having considered the responses of state government departments and authorities, the Office prepared this final report of the Investigation, including findings and recommendations, to be tabled in the Western Australian Parliament.