Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Kobie Ryder Blackaby

Find, Pursuant to Section 28(1) of the Coroners Act 1995, that:

a) The identity of the deceased is Kobie Ryder Blackaby;

b) Kobie died in the circumstances described below;

c) Kobie died on 25 February 2014 at the Royal Hobart Hospital at Hobart in Tasmania;

d) Kobie died as a result of drowning;

e) Kobie was born in Hobart, Tasmania on 18 August 2012 and was aged 18 months at the time of his death.

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Kobie’s death. The evidence comprises an opinion of the State Forensic Pathologist as to cause of death, relevant police and witness affidavits, medical records and reports, and forensic evidence.

I make the following further findings, based upon the evidence, as to how Kobie’s death occurred.

Kobie’s parents are Kacee Leeanna Fisher and Timothy Todd Blackaby. His two older brothers are Riley and Conna Blackaby. Ms Fisher and Mr Blackaby stated that Kobie was a child with a warm, loving and outgoing personality and that he developed close bonds with both of his brothers, particularly Riley, the eldest, whom he idolised. Kobie displayed intelligence and was quickly able to learn new words and was able to sing to his family at the age of 15 months.

On 25 February 2014, Kobie was taken by his mother to watch his older brother’s running carnival at Boyer Oval. They returned home shortly after 11:45am. Kobie went to sleep and woke again at about 2.30pm. At around that time, a friend, Luke Green, visited the family. Mr Green also took his daughter, Kortay, with him. Kortay played with Conna. At approximately 4.15pm Mr Blackaby arrived home and spent some time talking with Mr Green. Ms Fisher had chastised Conna and Kortay during this time for leaving the front security screen door open. She checked on Kobie who was in Riley’s bedroom watching him play X-Box.

Mr Blackaby and Mr Green spent a short while talking and went to smoke in the laundry before joining Ms Fisher in the lounge room. As Kobie was quiet, Ms Fisher searched the bedrooms for him with no result. She then ran out the front to look for him with Mr Green
following. Mr Blackaby looked out of the kitchen window and saw Kobie floating in the inflatable pool in the backyard. He ran into the backyard and pulled Kobie from the pool and laid him down and began attempting CPR as Kobie was not breathing. Mr Green tried to help administer CPR for a short time. A neighbour came to the property and assisted Mr Blackaby with CPR.

An ambulance was called and ambulance officers attended. Police officers also attended. Ambulance officers noted that Kobie was not breathing and that he had no pulse. Resuscitation efforts continued but Kobie was pronounced deceased at midnight on 25 February 2014 at the Royal Hobart Hospital.

An autopsy of Kobie was conducted on 27 February 2014 by Dr Donald Ritchey. Dr Ritchey found that the cause of Kobie’s death was consistent with drowning. He found no evidence of significant traumatic injuries or apparent anatomical cause of death.

The pool in which Kobie was located was an inflatable pool constructed of blue plastic. It was not inflated to its full capacity. Therefore the sides of the pool collapsed easily allowing water to escape with minimal force exertion. The material, shape and construction of the pool resulted in a bulge at the bottom section, below the inflatable rim at the top. The height of the pool was 600 millimetres and the diameter was 2550 millimetres. The actual depth of the water in the pool was 495 millimetres.

There was a pump and filtration line attached to the side of the pool. There was a warning printed on the side of the pool pertaining to fencing requirements and the requirement for adult supervision. There was no fencing preventing entry to the pool.

Ms Fisher and Mr Green both state in their affidavits that there were issues with keeping the front door closed during the afternoon whilst children were playing inside and outside of the house. This appears to be the point at which Kobie exited the house.

It is likely that Kobie, having made his way to the pool, leaned against the side of the pool which then collapsed, causing him to fall in. Once inside the pool, the inflatable rings would have returned to their normal position, preventing his escape.

Comments:

I make the following comments and recommendations pursuant to section 28 of the Coroners Act 1995.

In Tasmania, any pool which is deeper than 300 millimetres requires fencing in accordance with the requisite Australian Standard regardless of the type of pool and can include fixed pools, inflatable pools and spas. The requirement to comply with this fencing requirement, as per the Australian Standard, is imposed by the Tasmanian building legislation. Additionally, a building permit must be obtained from the local council for pools with a 300mm depth and which exceed a surface area of 9 square metres. The permit issued by a council will invariably impose a condition requiring fencing in accordance with the applicable Australian Standard.

With the introduction of cheaper and smaller portable and inflatable pools into the market, there appears to have been an increase in the number of pools in Tasmania which do not comply with Tasmanian pool fencing requirements. I am not, however, aware that any such increase has been officially monitored or that statistics are available.
It appears that some consumers may not be aware of the requirement to fence inflatable and portable pools in excess of a 300mm depth or the need to obtain a building permit for those with a larger surface area. The pool in which Kobie drowned was required to be fenced but was not fenced. If there had been fencing in compliance with requirements, then his death may have been prevented.

The Royal Life Saving “National Drowning Report” 2015 reported that for the period from July 2014 to June 2015 there were 14 drowning deaths in the 0-4 age bracket in swimming pools in Australia. The report notes that children under five years of age continue to form a high proportion of swimming pool deaths.

The report identified that the goal of reducing drowning deaths in the 0-5 age bracket should focus upon:

a) Strengthening education and training to increase parental or adult supervision;
b) Ensuring uniform pool safety fencing requirements and enforcement;
c) Ensuring that all children of school age receive compulsory aquatic education; and
d) Promoting rescue and resuscitation skills across the community.

I respectfully endorse these objectives.

**Recommendations:**

I recommend that the responsible State and local government bodies determine and monitor the extent of any increase in the number of portable and inflatable pools purchased in Tasmania, and, consequently, develop and implement appropriate water safety strategies relating to such pools.

I recommend that the responsible State and local government bodies incorporate into existing water safety awareness and education strategies, a public education and awareness campaign highlighting the requirement for approved pool fencing relating to the installation of portable and inflatable pools.

The above recommendations are supported by the Royal Life Saving Society Australia.

I convey my sincere condolences to family and loved ones of Kobie.

**Dated:** 12 July 2016 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner