REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Managing Director** **The Dalmeny Hotel** **19 – 33 South Promenade** **Lytham St. Anne's** **Lancashire** **FY8 1LX**
1	**CORONER** I am Alan Wilson, Senior Coroner, for the area of Blackpool & Fylde
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** **The medical cause of death was recorded as follows:** **1 a Drowning** The conclusion was that "Jane Bell died as a result of an accident". .
4	**CIRCUMSTANCES OF THE DEATH** In box 3 of the Record of Inquest the following was recorded: "Jane Bell died in the Paediatric intensive care unit at Manchester Children's Hospital at 19.55 on 14th August 2014 as a result of drowning caused by a deliberate human act which has unexpectedly and unintentionally taken a turn that leads to death. Inadequate staff training and pool supervision are considered contributing factors". In more detail the circumstances were: • This incident that was captured on the hotel CCTV system. Jane Bell was being supported by her Mother in the deep end of the hotel pool when she went under the water where she remained for almost two minutes until a hotel guest dived into the water and rescued her. She was revived initially, taken to hospital but later passed away. At the time she was wearing no arm bands although these

- At the time of the incident there was no constant pool side supervision by hotel staff.
- There was some signage in the pool area which included advice for swimmers including information about the pool depth and that only competent swimmers should go beyond a certain point in the pool but the inquest heard from one witness that because she felt that her Great Nephew, aged 10, was what she regarded as a strong swimmer she didn't pay much notice to the signs.
- The inquest heard how before the child was rescued from the water by a hotel guest, a member of the leisure staff who had been working on the reception desk had dived into the water but was unable to retrieve the child from the pool floor, although at that time she had not received pool response training that may have assisted her in rescuing a casualty from the bottom of the pool [which she has subsequently received].
- Staff who worked on the reception desk were expected to monitor activity in the pool by way of CCTV footage. On the morning of the incident a member of staff spent at least 90 minutes working alone in reception and given the other duties he was expected to carry out he was unable to constantly view the pool area by way of the CCTV monitor and during that period there were no staff pool side in the pool area.
- Another hotel guest explained in a statement that he and his young family had made use of the hotel leisure facilities previously, had noted the leisure club staff around the pool side areas, and specifically recalled leisure staff being visible and blowing their whistles to attract the attention of swimmers during what he described as "float time". He was conscious of the need for children to wear armbands, said that there is a clear divide from the shallow to the deep end; that anyone beyond that divide would have to be a strong swimmer to look after a 3 year old child
- A Leisure Manager confirmed that staff has received 1st Aid and pool response training in November 2014 but not at the time of this incident. The training involved entering the water to assist a casualty, and had included simulation using a "dummy", and a monthly refresher.
- The inquest heard that although there is safety equipment available, whilst this could assist in aiding someone struggling at the surface it would not help someone on the bottom of the pool.
- Staff will now patrol the pool side area at least hourly and when the numbers of

	• A Managing Director at the hotel said that since this incident the hotel had conducted a comprehensive review of policies and procedures in respect of health & safety and that as regards the issue of constant poolside supervision she explained that both the previous and the current consultants were of the view that although the industry guidance requires constant pool side supervision for this type of pool, but that this can be provided by way of a combination of factors including pool side checks and CCTV monitoring of the pool area. All members of leisure and entertainment staff have now been provided with poolside response training but that in the event of a pool emergency she would expect it to be one of two people in reception who respond and attend. • She confirmed that the hotel – in response to a report seen in January 2016 – propose to have work carried out this summer to make the pool shallower. • She told the inquest that the hotel may not be able to continue to operate the pool facility if a constant lifeguard were to be needed, and a later expert witness explained how lifeguards are allowed to work for an hour but then need 20 or 30 minutes off and so more than the one lifeguard would need to be employed. The hotel has approximately 33,000 guests annually and this incident was the first such incident at the hotel, and a Fylde Borough Council employee confirmed no previous issues had been raised by the Council with the hotel as regards the pool facility at the Dalmeny Hotel. • A Health & Safety expert witness said a pool operator such as the Dalmeny Hotel has three options available to it to reduce the risk of drowning in the swimming pool to an acceptable level. These were to provide a lifeguard, or alternatively to remove the hazard by changing the design to remove the deep water, or to increase control measures to include a reliable drowning detection system, qualified rescue staff, improved signs, training against a revised Normal Operating Procedure and ensuring patrols of the area every few minutes with improved CCTV. He said that pool side patrols in his opinion ought to be undertaken every five minutes and that he personally was not a fan of CCTV and that if CCTV is at times to be the primary source of checking the pool this was not in his view sufficient given the depth of the pool and because staff can be distracted.
5	**CORONER'S CONCERNS**

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows:

I am concerned that the arrangements which the inquest was told are currently in place at the hotel are such that there remains a risk of future deaths.

Although the inquest heard expert evidence to the effect that the requirement that there be constant poolside supervision can be met by a combination of other factors notably poolside patrols and CCTV monitoring and that the hotel aims to provide this, I am concerned that the way in which this is to be delivered is insufficient and the duty to write this report is satisfied.

There are now two members of staff employed in the reception area at all times when the pool is open to swimmers. However, although the proposed pool side patrols are to be undertaken at certain parts of the day at 15 minute intervals, at other times when the number of swimmers in the pool is lower these patrols may take place less often and up to a minimum of once per hour.

The inquest heard that on the day that Jane Bell died a Leisure Assistant was unable to constantly monitor the pool by way of the CCTV screen / monitor in reception because he was at that time trying to also perform other tasks such as booking guests into the gym, distributing towels etc. The hotel – as confirmed by the Managing Director at the inquest – takes the view that because two staff will now be based in reception that this will ensure those tasks can be performed whilst the other member of staff monitors the pool thereby ensuring constant supervision. I do not find this argument convincing to the extent I am satisfied the duty upon me to write this report is not met. The expert witness told the inquest that he was “not a big fan” of CCTV, and it appears to me that even with two members of staff in the reception area, and given the other tasks such staff have to deal with, it is unlikely that between them the two members of staff will always have the pool in their sight at all times.

This is concerning when considered in combination with the proposed pool side patrols. If it was envisaged that such patrols be undertaken at 5 minute intervals throughout times when children may be swimming in the pool, a few moments during which the reception staff may be distracted and dealing with other tasks and not observing the CCTV footage may be less of a concern because a member of staff undertaking patrols at 5 minute intervals would have the chance to observe families, assess if they are complying with the rules set out on signs within the pool area, and recognise whether swimmers who need floatation devices such as arm bands are indeed using them.

However, if such patrols take place less frequently the chances of the staff performing those patrols identifying issues that may place a child swimmer at risk are diluted. This appears to be a concern even if the hotel does facilitate patrols at 15 minute intervals as they propose at all times during which the pool is occupied by families. At present, a family may enter the pool and be swimming in the pool for some time, and maybe up to an hour, before being observed by a member of staff patrolling the pool area should that family chose to use the pool at a time of low occupancy. This may not be a problem if they area family who are not safety conscious, are unaware that there is no constant pool side presence, have over-estimated their child's swimming ability and paid insufficient attention to the pool signage as a result, are not complying with the hotel regulations for whatever reason. A problem then arises if that family is allowing a child to swim alone or in the deeper half of the pool or without floatation aids when they need one.

Jane Bell was under the water for slightly less than two minutes and this proved fatal. I am concerned that reception desk staff may be distracted for a similar time leaving them unable – in spite of the encouraging work that has been undertaken since this fatality to train leisure and entertainment staff in first aid and pool side rescue which the expert witness felt ought to enable staff to effect a pool rescue – to rescue a child and prevent a similar fatality. The time needed to assist a child under the water is limited and

	poolside safety equipment at the hotel is limited to devices that may be used to assist someone struggling on the surface but not necessarily a child under the water. The impression given during evidence at the inquest was that the hotel management felt that there is a marked difference between time of high pool occupancy and other times when the use of the pool is much less. The concern about future deaths does not arise in respect of times when the pool is empty or when only adults are using it. The concern arises when perhaps only one or two families are using the pool. The evidence provided at the inquest suggested that at such times, pool side patrols would take place much less often that at fifteen minute intervals and I am concerned that more infrequent patrols – when families are using the pool – would not satisfy the requirement for constant supervision. Indeed as the expert witness stated at the inquest, he was of the opinion that such patrols ought to be conducted at five minute intervals. At the conclusion of the inquest, I indicated to the Properly Interested Persons that I proposed to write to the Trust by way of a report in accordance with the provisions of paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th May 2016. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: • The family of Jane Bell • Chief Executive of Fylde Borough Council • Chief Executive of Blackpool Council • Chief Coroner of England & Wales

	I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	A.A.Wilson **Alan Wilson** **Senior Coroner for Blackpool & The Fylde** **Dated: 22nd March 2016**