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The Coroner
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Date

06 September 2017

Dear Sir/Madam

RESPONSE TO REGULATION 28 REPORT - WAVENEY RIVER CENTRE

The evidence from South Norfolk Council was that the management of the swimming pools has one of the most prescriptive Health and Safety Guidance documents produced by the Health and Safety Executive. The Council accepted that for a pool of this size and depth with its features, there would be no need to continuously supervise the pool. This is the reason why swimming pools in hotels and swimming pools in leisure centres for example routinely do not have lifeguards.

The Council accepted that this remains their view today and a detailed review by one of the leading consultants following the sad incident involving Maya confirmed that the pool would not require continuous supervision by way of lifeguarding, or in any other way.

The evidence was that the Centre would on occasion privately hire its pool to people that wanted to hire it for swimming pool parties. The evidence of the hirer on this occasion was that she knew in advance that there would be no lifeguard. The evidence given by WRC confirmed that she was also told this in advance. This was not challenged by the hirer who said that she could not remember. There was also a very prominent sign on the entrance to the pool making it clear that there was no lifeguard.

The evidence was therefore absolutely clear that the hirer on this occasion knew that there was no lifeguard and was responsible for the supervision of the children attending her child's party.

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Her evidence was that there had been no discussion with parents as to the swimming ability of their children and that she had undertaken supervision with other parents from an observation area overlooking the pool. However, she also confirmed that she had left this area on a number of occasions, including to go into the changing rooms. She accepted that there were no discussions with other parents to ask them to take on the responsibility of supervision in this period and also confirmed that at the time Maya was found she did not think that there was any adult in the observation area adjacent to the deeper end of the pool where Maya was found.

It therefore gives a misleading impression of the evidence in the Regulation 28 Report to state "It was clear from the evidence it was believed by those at WRC to be the responsibility of the person holding the party who would be responsible for the safety of the guests." This was the evidence of the private hirer as well.

As the report does state, independent contractors had drawn up the Risk Assessments and other health and safety documentation relating to WRC and use of its facilities by staff and the public, specifically the regime for the use of the swimming pool was established by those consultants. The risk assessment, the Consultants created, included a specific question asking whether there is any equipment or activities to generate excitement. As stated, South Norfolk Council accept that this pool does not require continued supervision and the only issue between them and the Centre is whether or not a separate Risk Assessment should have been undertaken for swimming pool parties. This is against the background that in 2011 South Norfolk Council wrote to WRC to state that it believed its Risk Assessment for the pool was suitable and sufficient. In addition, there is no certainty, as South Norfolk Council fairly acknowledged when giving evidence that a separate risk assessment would have led to the pool being lifeguarded during parties.

A decision was made following this sad incident that the Centre would no longer privately hire its pool for swimming pool parties and the relevant risk therefore that is said may have caused Maya's death no longer exists.

In terms of wider training, the independent safety consultants who had worked closely with the company over many years had provided many hours of mentoring and on the job training and assistance to the Managing Director of the Centre and another member of his staff. Whilst it is correct that they had not undertaken formal training, the only evidence on this subject was from the Managing Director of WRC. He gave evidence that mentoring was focused and the Centre has been run with an excellent safety record for 14 years. The evidence was that the Centre takes safety extremely seriously. There was no evidence that any other aspect of WRC's safety management may be insufficient.

The Managing Director made it clear in his evidence that this incident had caused him to think that further training would be prudent and that there was an intention by the Centre to send staff onto formal safety training courses such as IOSH. His evidence was that this would be taken forward once the inquest had concluded. That remains the case and WRC's response to this notice is that such formal training has already been

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arranged, as was the Company's intention. However, WRC is very sensitive to any suggestion that its management of safety generally was deficient as there was no exploration of its systems at the inquest beyond the management of its swimming pool. In relation to that, as stated, WRC no longer hold pool parties and the accepted evidence of South Norfolk Council is that its pool does not require continuous supervision for its general use.

Yours faithfully

Kennedys