Regulation 28: Prevention of Future Deaths report

Catherine Mary GIBBON (died 02.06.18)

	THIS REPORT IS BEING SENT TO: **1. Mr Martin Long** **Chief Executive Officer** **DW Fitness First** **Whelco Place** **Enfield Street Industrial Estate** **Wigan WN5 8DB** **2. Mr Steven Ward** **Chief Executive Officer** **UK Active** **4th & 5th Floor** **26-28 Bedford Row** **London WC1R 4HE**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 11 June 2018, I commenced an investigation into the death of Catherine Mary Gibbon, aged 44 years. The investigation concluded at the end of the inquest on 11 October 2018. At inquest, the jury made a narrative determination, which I attach. The medical cause of death was recorded as: 1a hypoxic ischaemic brain injury 1b non fatal drowning 1c epilepsy

4	**CIRCUMSTANCES OF THE DEATH** Catherine Gibbon was swimming in the pool at the Tottenham Court Road branch of Fitness First on Friday, 1 June 2018, when she suffered a seizure. She floated head down in the water for around ten minutes before she was seen by another gym member. During this period of oxygen deprivation she sustained a brain injury that resulted in her death. Early detection and prompt, appropriate first aid would probably have saved her life.
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. 1. When Ms Gibbon joined the gym, she was given a health pledge to read. In this, she agreed to inform a member of staff if she had a medical condition that might interfere with exercise. However, she was not given any assistance in understanding which medical conditions would come in to this category. Even the staff taking her through the health pledge did not have a clear understanding of this. 2. There was also no clear understanding across staff of what additional help, if any, could be offered to a swimmer with epilepsy. Any understanding seemed to concentrate upon Ms Gibbon obtaining a doctor's letter authorising swimming. Whilst there is of course merit in prompting a discussion with a potential swimmer's doctor about the advisability of swimming, Fitness First indicated that constant monitoring of such a swimmer will not be offered. 3. The pool was not under continuous supervision and there was no legal requirement for a lifeguard, but it was under CCTV surveillance. The CCTV monitor was in reception. However, no training or guidance was given to the gym receptionist about what she should look for on the monitor and what she should do if all was not as she expected.

	Most especially, she was not given any instruction as to how frequently to check the monitor. 4. The receptionist also gave evidence that in her opinion, the screens (the monitor was split into four screens for the four cameras) were too small to see the pool activity clearly. 5. In fact, one of the four cameras had been broken since 24 May. It had not reported and no alternative measures had been taken since it had become non operational. Three minutes and 20 seconds after her seizure began, Ms Gibbon floated a short distance into the field of the broken camera. From this point, she was completely out of sight of the CCTV monitor. 6. There was no panic button that would activate an audible alarm throughout the building, so anyone pressing a button would not know if it had alerted others, and staff elsewhere (other than at reception) would be unaware that there was an emergency. 7. There was no landline at poolside that could be used to call an ambulance in case of emergency, to enable medical assistance to be summoned immediately by someone who actually had sight of the casualty. 8. There was a defibrillator in the gym, but there was not another at poolside. 9. Fitness First had made the decision that all first aid certificates would be renewed after one year rather than the usual three, but then the certificates were allowed to lapse because one person made an error and there was no failsafe system. Fitness First have taken steps to address some of these issues, and told me that such learning is shared at a national level. However, at inquest Fitness First national lead for health and safety told me that he was unaware that I sent a prevention of future deaths report to Bannatyne's on 13 August 2018, regarding a death in similar circumstances in Maida Vale on 10 October 2017. I did copy this report to Swim England, but this does not appear to have prompted a national conversation among private pool providers. I leave that now with UK Active.
6	**ACTION SHOULD BE TAKEN**

	In my opinion, action should be taken to prevent future deaths and I believe that you 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 24 December 2018. 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Camden Council, Environmental Health Department • Swim England • Sport England • [redacted], parents of Catherine Gibbon 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 24.10.18