Regulation 28: Prevention of Future Deaths report

Anthony Cleon GRANT (died 19.08.16)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Director** **Royal Life Saving Society UK** **Red Hill House** **227 London Road** **Worcester WR5 2JG**
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 25 August 2016, one of my assistant coroners, Richard Brittain, commenced an investigation into the death of Anthony Cleon Grant, aged 56 years. The investigation concluded at the end of the inquest on 19 October 2017. The jury made a narrative determination at inquest, which I attach. I apologise for the delay in the making of this report, brought about because I have been making further enquiries.
4	**CIRCUMSTANCES OF THE DEATH** Mr Grant was swimming in the public pool at Mile End Leisure Centre (managed by Greenwich Leisure Limited) when he suffered a cardiac event and drifted to the bottom of the pool.

	A member of the public noticed him and alerted the lifeguard, who performed an emergency rescue. Lifeguards gave cardiopulmonary resuscitation, but this was not successful and Mr Grant died on poolside.
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. Mr Grant drifted under the water and remained submerged for five minutes and 41 seconds before a member of the public noticed him and alerted a lifeguard. The lifeguard had been on duty on poolside throughout. Quite apart from the actions of an individual lifeguard, there are many ways that pool safety could have been approached differently that day. The lifeguards could have changed position after half an hour or an hour as had been intended. There could have been more than one lifeguard on poolside. The lifeguards could have been supported by a motion early warning system. These are all matters for the industry to explore. I write to you specifically because Mr Grant's family have given their consent for me to forward to you the footage of the pool CCTV from the time when he first got into difficulty to the end of the attempted rescue, in the hope that you will be able to make this, or at least part of this, nationally available as a training tool. This is obviously an incredibly generous act on the part of Mr Grant's family, but I imagine that they would prefer Mr Grant's name not to be used when showing the video, particularly as some of his children are still minors. I am aware that your organisation has already made training DVDs, but it seems to me that there is something uniquely powerful in lifeguards in training being given the opportunity to watch real events such as those on this clip. It provides the most vivid reminder possible of the need for constant vigilance on poolside. Once seen, this is a piece of film unlikely to be forgotten, and Mr Grant's family hope it can be used to save other lives.
6	**ACTION SHOULD BE TAKEN**

	In my opinion, action should be taken to prevent future deaths and I believe that you and 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 15 January 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 • [redacted], daughter of Anthony Grant • [redacted], managing director, Greenwich Leisure Limited • Chartered Institute for Management of Sport and Physical Activity • UK Active 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** 16.11.17