Response by Bannatyne Fitness Limited to the Regulation 28 Prevention of Future Deaths Report in the matter of Kamal Al-Hirsi (date of death 10.10.17)

1. Mr Al-Hirsi cleaned the pool by diving down with a suction hose and holding his breath. This had always been the method at Maida Vale, because there was no pole or extension head. Whilst this did not have an impact on Mr Al-Hirsi's death, evidence was heard that it was inherently dangerous.

   Prior to the incident, the Board of Directors of Bannatyne Fitness Limited ("the Company") were unaware that the pool at Maida Vale had been cleaned in this unauthorised manner. Steps have now been taken across all of the Company's sites to ensure that pools are not cleaned using this method. It is understood however that this was an isolated occurrence and not commonplace in the Company's other sites. For the record however, the Company wishes to state that the evidence given at the inquest did not show, certainly to the Company's satisfaction, that this method of cleaning, whilst not acceptable, was "inherently dangerous". Indeed the pool had been cleaned at Maida Vale in this way for a number of years without incident, and as the evidence confirmed, it played no part whatsoever in Mr Al Hirsi's death.

2. No thought appeared to have been given to the fact that the cleaner who often partnered Mr Al-Hirsi in the pool cleaning process, standing on poolside and directing him, was a non-swimmer and not confident to enter the water even at a depth of 1.5m. In the event, she relied on a club member to undertake the rescue.

   The Company has clarified and reissued instructions to all of its Clubs to reaffirm that no employee is to enter the water for purposes of cleaning the floor of the swimming pool.

   The Company has updated its recruitment processes and introduced a new question on it's CV Supplement Application Form in order to determine the swimming competency of its new employees, which can then be utilised when allocating responsibilities. The Company will also ascertain the swimming competency of its existing employees by 14 October 2018.

   It is also the Company's intention to upskill its designated first aiders to have a pool responder qualification. We will endeavour to complete this by 31 December 2018.

3. Members of staff had not been given any water safety awareness training. Some did not have a proper understanding of the ways in which a person in difficulty in the water may present, for example that they will not necessarily wave in distress, and that they may sink rather than float. Mr Al-Hirsi simply sank to the bottom of the pool. Bannatyne's had not trained staff in the use of pool lifesaving aids. The cleaner who first tried to help Mr Al-Hirsi attempted to poke him with a float, but the float did what it was meant to, it floated.

In January 2018, the Company employed two new members of staff; a Health & Safety Compliance Manager (who was previously employed by the Company's Primary Authority) and a Learning & Development Manager to improve its training and compliance. Subsequent to this, the Company procured and, in May 2018, launched a new online Learning Management System. In order to enhance its employees' existing knowledge, all staff are currently undertaking mandatory training modules.

The Company has introduced a new module on its Learning Management System on water safety awareness, which will be mandatory for all employees of the Company. The Company will ensure that all existing employees complete this by 31 October 2018.

The Company also now requires all of its new and existing employees to undertake a documented Workplace Induction Checklist, where they will be given a guided tour of their site to ensure that they are aware of the location and use of the building's emergency and life saving apparatus. The Company will ensure that all existing employees complete this by 15 November 2018.

4. Some members of staff did not know the exact location of the panic buttons, nor the circumstances in which they should be pressed. The panic buttons did not sound 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. It did not occur to the cleaner who first realised that Mr Al-Hirsi was in difficulty to press the alarm, but even if she had, this would not have brought other staff running to help.

   Giving evidence in a Coroner's Court, and reliving the events of the day when Mr Al Hirsi died, was extremely stressful and emotional for those Company's employees who attended. This, combined with language barriers, resulted in them being confused, which meant that regrettably, their evidence did not accurately reflect the actual circumstances of their day-to-day knowledge of the Maida Vale Club. For example, Mrs Islania was originally employed as a Domestic (cleaner) at the club and it was her responsibility to clean and dust the panic buttons located around the building.

   As noted above, the Company requires all of its new and existing employees to undertake a documented Workplace Induction Checklist, where they will be given a guided tour of their site to ensure that they are aware of the location and use of the building's emergency and life saving apparatus. The Company will also review its Emergency Action Procedures ("EAP") and ensure that its employees participate in regular documented drills. The Company's new Health & Safety Compliance Manager will audit these centrally on a quarterly basis from 1 October 2018.

5. The panic button alarm was audible by a beeping sound in reception and a light was illuminated on a control panel there, but this relied solely on the reactions of one individual who was not necessarily first aid trained and, if the receptionist did call 999, s/he would not necessarily know the nature of the emergency. In this instance, the receptionist who called an ambulance did not know that Mr Al-Hirsi had suffered a cardiac arrest.

   The Company will also review its EAPs and ensure that its employees participate in more regular documented drills to cover multiple emergencies. The Company's new Health & Safety Compliance Manager will audit these centrally on a quarterly basis from 1 October 2018.

   The Company has reviewed and amended its EAP, procedures and notification process for emergencies at the Maida Vale Club. Receptionists have been re-trained in recognising an alarm and the immediate next steps to be taken. The panic buttons when pressed will activate an automated message, which will be audible from all member areas of the Club and will notify all staff, including the Duty Manager(s), to muster at the Club's Reception. The Duty Manager will dispatch employees to the emergency together with the Defibrillator and the other emergency equipment. The Company's contractors will complete the installation work by 10 October 2018. It is the Company's intention to pilot this revised emergency response system at its Maida Vale and Durham health clubs. Following a review of these systems, the Company intends to roll it out across its estate.

6. The protocol in place was that, on hearing an alarm, the receptionist should simply contact the duty manager (who was the designated site first aider): first by radio; failing that by sending someone to find him; and failing that by ringing the duty manager's mobile phone. The receptionist gave evidence that the radios often didn't work, though the regional manager disagreed. When the receptionist was notified that there was an emergency, she could not use the radio because the duty manager had not picked a radio up; she was unsure where he was; and when she rang him on his mobile, she did not get through because there is a poor reception in the plant room where he was working

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7. There seemed a lack of meaningful awareness of the defibrillator location and function. The first person trained in CPR (cardiopulmonary resuscitation) to respond to the calls for help was a freelance personal trainer who was not a member of Bannatyne staff. Although he was trained, he did not take the defibrillator (there was only one and it was located in the gym) with him, because at that stage he did not know that Mr Al-Hirsi had suffered a cardiac arrest. Some staff members had not received defibrillator training. When the personal trainer reached Mr Al-Hirsi and realised the exact nature of the emergency, the only other person on poolside at that point who seemed confident of the location of the defibrillator, was a club member who happened to be a retired doctor.

   At the time of Kamal's death there was signage at the Club's reception stating the whereabouts of the defibrillator. This was standard at all of the Company's sites; defibrillators were not encased or hidden away in offices, but were located in a bracket on gym floors clearly signed in prominent locations and visible to employees, members and visitors. However, following the inquest and your Regulation 28 Report, the Company has taken the decision to relocate defibrillators to sites' reception area, where they can be readily seen and accessed by all. The Company can confirm that this has been completed across all of its sites.

   The Company has also reviewed its EAPs, procedures and notification processes across all of its sites.

8. The pool was not under continuous supervision and there was no legal requirement for a lifeguard, but it was under CCTV surveillance. However, the camera was placed at in such a position that it could not detect what was happening under water, and there was a blind spot in that part of the pool nearest the camera. After Mr Al-Hirsi slipped under water, he was completely invisible to the camera.

   The Company has undertaken a review of its CCTV coverage of the pool at its Maida Vale Club and has commissioned the work for the repositioning of the CCTV cameras. These works will be completed by 31 October 2018 and will include additional cameras to remove the blind spot noted at the Inquest. It should be noted that the purpose of these cameras is to monitor the number of people within the poolside environment as identified in HSG179. The images from these newly positioned cameras will be available to view on the monitor at reception.

9. The CCTV monitor was in reception. This was meant to be observed every 15 minutes (to ensure maximum bather load had not been exceeded, rather than to look for bathers in distress), but these observations had fallen out of practice, and the monitor was behind the head of the receptionist, so it was never in her normal field of view. She had to turn her back on the public to look at it.

The Company has moved the CCTV monitor at its Maida Club to a more suitable location so that the CCTV monitor is in the constant line of sight of its Receptionists. The Company has also reinstated the 15 minute CCTV checks at its Maida Vale Club, which formed part of the Company's Normal Operating Procedure and risk assessments.

10. The written procedures did not detail the action that should be taken on noting a bather in difficulty; they talked about RLSS (Royal Life Saving Society) techniques being used but these were never taught; and the duty manager at the time gave evidence that he did not ever remember reading the standard operating procedures or emergency action plan

The Company has removed references to RLSS techniques from the Club's documentation. This was an unfortunate error. In September 2017 the Company set up a Water Users Group consisting of representatives of the Company's general managers, regional operations managers, regional estates managers, the Company's board of directors and external stakeholders/suppliers. The Company has widened the scope of the Water Users Group's remit and will review and update the Company's procedures in relation to this area by 31 March 2019.

Of particular concern to me is that, ten months following Mr Al-Hirsi's death, many of these practices remain entirely unchanged. For example, evidence was heard that no thought has been given to obtaining another camera; no thought to moving the CCTV monitor; and no thought to giving the staff water safety awareness training. Some refresher training is being given, but this was only started two weeks before the inquest began on Monday, and still no consideration has been given to including the freelance personal trainer (whose response to Mr Al-Hirsi was immediate and effective) in training regarding health and safety procedures within the club.

Pending the outcome of the inquest, and investigations by the Metropolitan Police and the London Borough of Camden, the Company was advised not make any changes to its policies and procedures. Changes will now be implemented at both Maida Vale and across the Company where necessary, in the light of the concerns that have been raised.