Regulation 28: Prevention of Future Deaths report

Kamal Yahyia AL-HIRSI (died 10.10.17)

	THIS REPORT IS BEING SENT TO: **1. Mr Justin Musgrove** **Chief Executive Officer** **Bannatyne Group** **Bannatyne Head Office** **Power House** **Haughton Road** **Darlington** **DL1 1ST**
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 16 October 2017, I commenced an investigation into the death of Kamal Al-Hirsi. The investigation concluded at the end of the inquest on 9 August 2018. The jury made a narrative determination, which I attach. The medical cause of death recorded was: 1a acute cardiac arrhythmia 1b cocaine and alcohol toxicity and fatty liver disease
4	**CIRCUMSTANCES OF THE DEATH**

	Mr Al-Hirsi worked as a cleaner at the Bannatyne Health Club in Maida Vale, London. On the morning of 10 October 2017, he cleaned the swimming pool, swam two lengths and then slipped under water to the bottom, having suffered a cardiac arrhythmia. By the time his situation was appreciated, resuscitation attempts were too late to change the outcome. The pathologist gave evidence that any person may suffer an arrhythmia from a natural cause, but on this occasion the alcohol and cocaine (not dose related) were probably responsible.
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. 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. 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. 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.

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.

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.

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.

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.

	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. 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. 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. 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.
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 8 October 2010. 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 • [redacted], brother of Kamal Al-Hirsi 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** 13.08.18