

The Royal Life Saving Society UK in association with Quality Leisure Management Ltd

Life Changing Event DVD Trainers Guide

Version One- for Trainers working in the Sport and Recreation Industry

1. Objective of the DVD

This is a training tool for the ongoing training of both lifeguards and managers. It details how failure to plan the service and carry out the requirements of the role can change not only the lives of the bereaved and the victim, but also the employees own lives. A death or major injury to a member of the public or an employee can be a life changing event for everyone.

A key message is that in the DVD everyone meant well and nobody wanted the incident to happen, but complacency cost a life and changed everyone's life, not just the bereaved family.

The DVD shows how a typical courtroom scene in a criminal prosecution of an organisation under the Health and Safety at Work etc Act 1974 would be conducted. The aim is not to be totally precise on courtroom protocols but to show the impact on managers, supervisors and front line staff of such an incident.

No link with any real incident is intended and if perceived is entirely accidental. Whilst the scenario is not strictly true to the protocol of the courtroom, the principles are based on reality.

2. The Life Changing Event Scenario

The incident takes place in a typical swimming pool on a typical day. Public swimming is taking place. The pool is lifeguarded with the requisite number of lifeguards and the Lifeguard supervision position in the first scenario is appropriate for the pool. The first scenario shows the rescue conducted effectively in line with industry guidance and principles. The scene then moves to the incident where the child (Michael Thomas) drowns. In this second scenario the lifeguard chair is situated in an inferior position making it harder to see the bottom of the pool because of the impact of glare. This is a management failing. Michael Thomas is 11 years old and a weak swimmer. He has gone swimming with his friends, but his friends are elsewhere in the pool. Michael has entered the water and is out of his depth. The lifeguard, Rebecca Florence Smith, is distracted by engaging in conversation with her



friend and, whilst keeping an eye on the pool, Smith is not in the correct position and is clearly not paying full attention to her duties.

The expert, played by Alex Blackwell, highlights management and staff failings in the scenario and this leads to cross examination of the lifeguard, Rebecca Florence Smith and the Pool Manager, John Adam Mason. The scenario finishes with the judge passing sentence. This is inevitably a brief version of a full judgement. The organisation is fined £180,000 under the Health and Safety at Work etc Act 1974. No individual prosecutions have been brought against either the manager or lifeguard as it would be highly unlikely in this scenario that they would be prosecuted. Everybody meant well and there was no wilful or deliberate disregard for the law and both the organisation and the employee contributed to the fatality.

The final section of the DVD is an interview with Penny and Terry Matthews, whose son Nathan drowned in 2004. Penny and Terry are not actors, but are parents with five other children who live with the loss and life changing event of the death of their son through drowning. There is no criticism of the circumstances surrounding the drowning of Nathan Matthews, however the impact of the loss of a child is the same irrespective of fault.

3. Key Messages for the Trainer

The Trainer is encouraged to focus on the key messages for staff when using the DVD.

- a) An event such as a drowning or a major incident changes everyone's life, not just the bereaved. The key message of the training is that an event such as a fatality will live in the memory of those involved forever, so prevention through doing the job right first time is important.
- b) The Trainer can also reinforce the impact on the organisation. The reputation of the organisation in the community will be damaged and this will live long in the memory of the community and of course the Press. Experience has shown that reference to the event is made on a sporadic basis for some years to come.
- c) In the scenario there was no wilful disregard of the rules and standards required to operate the swimming pool and it is clear that everybody meant well, but complacency and failure to work to the required standards as defined by the industry are clear contributory elements to the drowning of Michael Thomas.
- d) Everyone's job is important. The provision of a reasonably safe environment for swimmers is achieved by the whole team performing their roles adequately.



- e) Managers must plan the service through risk assessment and implementation of safe systems of work. The role of risk assessment is crucial. Assessing significant hazards such as glare must be conducted to ensure lifeguards are in the appropriate positions. It is also emphasised that it is a management role through the supervisory team to monitor employee performance to ensure staff work in accordance with their training and continue to comply with the standards as laid down in the written operating procedures, particularly with regard to lifeguard positions in this scenario.
- f) It is therefore implicit that the supervisory team are also culpable in the drowning, even though there is no cross examination of Duty Officers or Supervisors in the DVD. The monitoring role of supervisory staff should be reinforced.
- g) Lifeguards and all staff who have duties to perform must perform them as per the defined standards and procedures and policies of the organisation. In this scenario the lifeguard failed to stay at the approved lifeguard position and when they did move it was not for reasons to execute their duties, but to engage in social conversation. Such distraction can occur with both staff and members of the public. The key message here is that people must remain switched on to their role and not relax. The scenario clearly shows that the lifeguard was keeping an eye on the pool, but not from the correct position and not providing sufficient and suitable supervision.

The drowning of Michael Thomas scenario is based on the following legal breaches:

- Health and Safety at Work etc Act 1974- Section 3 (1) failure in the employers duty to persons not in employment.
- Management of Health and Safety at Work Regulations 1999 (as amended) -Regulation 3 (1) (b) failure to ensure a suitable and sufficient risk assessment was conducted for persons not in employment.

Failure to comply with HSG179 (Managing Health and Safety in Swimming Pools) can be referenced by the Trainer in the discussion groups and in particular:

- Paragraph 16 Health and Safety at Work etc Act 1974.
- Paragraph 18- Management of Health and Safety at Work Regulations 1999 (as amended)-Risk Assessment.
- Page 41, section 3.2- Managing Glare.
- Page 47, section 6.11- Concealed or difficult to view water areas.
- Paragraph 135 Deployment of Lifeguards.
- Paragraph 142 Training and supervision of Lifeguards.
- Paragraph 143 Lifeguard functions.
- Paragraph 162 Ongoing training and resuscitation.
- Paragraph 179- Lifeguard surveillance positions.
- Paragraph 180 Lifeguard scanning.



4. How to Use the DVD

Whilst Trainers can show the whole scenario from start to finish, it is constructed so that individual sections can be shown to reinforce training requirements and standards. Therefore separate training sessions are encouraged with managers, supervisors and lifeguards.

Discussion and question and answers around current policies and practices are encouraged at the end of each section. Reinforcing the need for employees to perform their duties as per the defined standards is important. Everyone knows what should be done; the key issue is doing it!

5. The Drowning of Michael Thomas

The Trainer should note that both scenarios shot at GL1 Pool in Gloucester are role plays. The rest of the pool was open for public swimming and was fully lifeguarded by other members of staff. Therefore the pool was not evacuated as this would have disrupted the public simply to make a role play technically correct.

The Trainer is recommended to show the rescue of Michael Thomas section (what should have happened) followed by the scenario that forms the basis for the prosecution (what actually happened). The rescue performed as per the industry protocols is useful to set the scene, however the bungled rescue identifies a number of failings:

- Lifeguard moving from the position allocated in their written procedures.
- The Trainer should note that the lifeguard chair is in a different position in the bungled rescue to the correctly performed rescue. This is to reinforce the fact that the chair was in an inappropriate position due to glare. This is a failure in management planning through inadequate risk assessment.
- The lifeguard is talking to a member of the public and is looking over the public's shoulder to keep an eye on the pool.
- It will later transpire that the lifeguards had not attended the requisite ongoing training for Cardio-Pulmonary Resuscitation (CPR).
- There is no attempt in the role play to show the detailed CPR techniques, however the principle of attending ongoing training is important.
- The Trainer should also reinforce the need for competency testing to ensure persons are deemed competent as lifeguards as well as qualified.



Discussion Points

- a) The impact of glare and the process by which this and other perceived shortfalls in health and safety arrangements are reported to management and actioned.
- b) The ease by which an employee can be distracted. A normal day can lead to complacency.
- c) The violation of known safety rules by the employee. Think of other examples where this can occur.
- d) Importance of ongoing training and everyone's responsibility to attend.

6. The Expert

Examination in Chief of the expert, played by Alex Blackwell from RLSS UK, sets the scene for the successful prosecution. As this is a role play there is no cross examination of the expert's evidence. The expert points out that there is nothing unusual about the design of the pool which would impinge on the safe and proper management of the service.

The expert identifies management failings as follows:

- Failure to adequately risk assess for the hazard of glare and put lifeguards in an appropriate supervision position in the first place.
- Failure to use published industry guidance on risk assessment and in particular the ISRM Risk Assessment Manual.
- Leaving the positioning of lifeguards to deal with glare to the lifeguards themselves. Risk assessment and safe systems of work are a management responsibility.
- Inadequate information in the normal operating procedure on the required lifeguard supervision position. The expert reinforces that standards should be set by management and defined with precision in the normal operating procedures.
- Failure to ensure staff attend monthly ongoing training in line with established industry good practice. Ongoing training records identify possible shortfalls in the ongoing training of the lifeguards which therefore questions the competency of lifeguards. No decision is arrived at in the trial, but doubt is expressed as to the competence of staff due to the failure to attend required ongoing training. The Trainer will need to reinforce this key issue.

The Expert identifies employee failings as follows:

• The lifeguard is distracted by talking to a member of the public and has left her allocated position.



• The lifeguard does not follow her training by staying in the allocated supervision position.

Discussion Points

- a) The importance of risk assessment. Is your site risk assessment suitable and sufficient?
- b) Do management have access to and use published industry guidance on pool safety?
- c) Does your NOP define with precision lifeguard positions and scanning zones?
- d) Is your NOP clear regarding whether the lifeguard should patrol or stay in the high chair position?
- e) Is there a clear and robust training plan to maintain staff competence?
- f) Do employees attend training on the required frequency and are they tested as to competence?
- g) Do manager's monitor attendance at ongoing training and take action when staff fail to attend?

7. Cross Examination of Rebecca Florence Smith

The lifeguard is played by Anna Shearer. The scenario shows the cross examination only. In the trial Rebecca Smith will have provided Evidence in Chief to the Defence Barrister before being cross-examined. The cross examination by a Barrister is a stressful event for any person: for a lifeguard who has never envisaged being in this position, it can be positively traumatic. The training message is that this event, as well as the original incident, will stay in the lifeguard's memory for ever.

Being in the witness box can be a memory test and the danger of using half hearted excuses or inaccuracies is exposed (e.g. non attendance at training and reason for chatting with a friend). Remember the Barrister is well briefed.

Rebecca Smith is a fully qualified and experienced lifeguard.

The Trainer should note how the Barrister leads the lifeguard through the key issues and repeatedly comes back to the failings at various points. Rebecca Smith first of all confirms what is reasonable practice in terms of vigilance and scanning the pool before the Barrister exposes her shortfall in performance. The Barrister prods away at the issue of observation and distraction of the lifeguard and eventually the lifeguard herself realises that in hindsight she would have done it differently.

The Barrister conducting the cross examination focuses on considerable detail from the working practices and records from some years ago and it is difficult for an individual witness to recall past events. The Trainer should note how easy it is for a Barrister to expose shortfalls in training and training records.

The Trainer should reinforce the message that the lifeguard only switched off for a minute. It was a normal day and a normal swimming session; there was nothing out of the ordinary. Complacency contributed to the fatality.



The cross examination of the lifeguard is also used to identify failings of the manager, John Adam Mason. Rebecca Smith is asked to comment on her feedback and complaints to management, i.e. concerns over lifeguard positions. This information is then further used in the cross examination of the manager, John Adam Mason.

Discussion Points

- a) Did the lifeguard do her job in accordance with her training?
- b) How do you think Rebecca felt after the cross examination?
- c) How do you think she will feel five years further on?
- d) Discuss other workplace scenarios that could result in the death or serious injury to a member of public or another employee. Examples include plant room, maintenance works, food preparation, coaching and holiday activities.

8. Cross Examination of John Adam Mason, the Pool Manager

John Adam Mason is played by Steve Wood who is a former swimming pool manager. As with the lifeguard cross examination, the Trainer should focus on the most stressful of moments of the cross examination from the individual employee point of view. Cross Examination would follow on in reality from the Examination in Chief by the Defence Barrister where the position of the defence in operating the pool reasonably would have been argued to the Court.

In the role play Cross Examination is constructed to lead the witness through the key issues of failings in training, inadequate risk assessment and the failure to uphold standards of operation through effective monitoring of employees by the Manager and the Duty Officer supervisory team.

The Barrister is at times sarcastic about the experience of the Manager and provides a robust interrogation to expose the failure to plan the service and manage then the pool operations effectively.

The role play shows the futility of the Manager trying to use his professional and technical knowledge to argue his case. For example the failure to thoroughly risk assesses lifeguard supervision positions. The Barrister will be well briefed.

John Mason by the end of the cross examination wishes he could turn the clock back and finishes with a statement: "We all meant well". The Trainer should reinforce this phrase. Good intentions are no assurance of satisfactory performance. The Manager was complacent about setting and upholding safety standards.

The Trainer should reinforce that the management of the service requires:

- Thorough risk assessment,
- Effective normal operating procedures which clearly state with precision the required standards of operation
- Trained and competent staff



- That standards should be upheld by ensuring successful attendance at training. Monitoring of attendance and competency testing should also be in place.
- Monitoring of performance by supervisory staff.

The Trainer should also reinforce that Managers' manage the service and set key safe systems of work such as lifeguard positions. Whilst this can be in conjunction with the lifeguard team through consultation, the ultimate responsibility lies with management.

John Mason is left in no doubt in the cross examination that he is culpable in the death of Michael Thomas and that the event will live with him. Trainers should also reinforce that cross examination and the experience of being in Court is traumatic in itself and again will remain in the memory.

Discussion Points

- a) Are your organisation's risk assessments and NOP's robust to manage workplace hazards? (Expand discussion to cover a broad range of issues).
- b) Is suitable and sufficient training in place and delivered?
- c) Are safe working practices upheld by your supervisory team?
- d) Did John Mason do his job in accordance with his training and experience?
- e) How do you think John Mason felt after the cross examination?
- f) How do you think he will feel five years further on?
- g) Discuss other workplace scenarios that could result in the death or serious injury to a member of public or another employee. Examples include plant room, maintenance works, food preparation, coaching and holiday activities.

9. Sentencing

The organisation has been found guilty and the sentencing scenario is brief. In reality statements of mitigation would have been submitted by the Defence following the guilty verdict. It is the organisation (not the individual) being prosecuted under Health and Safety at Work etc Act 1974 and therefore the imposition will be only financial. There is no suggestion in this scenario that individuals will be prosecuted.

Discussion Points

- a) Is the fine of £180,000 appropriate?
- b) What would the impact of such a fine on your organisation be?
- c) If you were Rebecca Smith or John Mason what would stay in your memory longer, the financial impact on your employer or your part in the death of Michael Thomas?

10. Nathan's Story

The interview with Penny and Terry Matthews, parents of Nathan Matthews who drowned on 11th July 2004 in a public swimming pool, provides an insight into the



reality of the death of a child. Nathan was 11 years old when he drowned and the impact on the parents and the 5 brothers and sisters of Nathan are recounted in this short interview with Penny and Terry.

The drowning of a child will have a major impact on a family. We are grateful to Penny and Terry for sharing their thoughts and feelings. The Trainer should use this at the conclusion of the training to reinforce to lifeguards, supervisors and managers as to the impact on others of failing to get it right first time.

Discussion Points

- a) What can your organisation do to reduce the risk of Nathan's story being repeated?
- b) What improvements can you make individually?





IQL UK Ltd manages the National Pool Lifeguard Qualification (NPLQ) and the National Pool Management Qualification (NPMQ) on behalf of the Royal Life Saving Society UK*.

The Institute of Qualified Lifeguards is the awarding body of the Royal Life Saving Society UK and the largest awarding body for lifeguard qualifications in the UK with over 42,000 awards processed each year, the National Pool Lifeguard Qualification is available in over 2200 of our Approved Training Centres,

As the leading industry expert in swimming pool safety management, IQL UK Ltd is passionate about providing excellent customer service through the highest possible standards of health and safety, we believe that our awards are the best in the industry.

We consider safety to be paramount and our rigorous internationally recognised <u>National Pool Lifeguard Qualification</u> is designed to ensure pool lifeguards and operators are equipped to deal with almost any water emergency. The NPLQ meets the requirement of the HSE publication "<u>Managing Health and Safety in Swimming Pools</u>"

IQL UK Ltd (IQL) developed the NPMQ qualification on behalf of the RLSS UK in direct response to the findings contained in an industry survey carried out by Leisure Net Solutions Ltd in 2008. The NPMQ is designed to equip any level of Manager in a swimming pool environment with a clear understanding of their legal responsibilities and their employers responsibilities with regards to Health & Safety. For further information on the 4 day course please visit www.igl.org.uk/npmg

Further information can be found on our website www.iql.org.uk and the IQL UK team can be contacted on 01789 773994

*IQL UK Ltd is a wholly owned trading subsidiary of the Royal Life Saving Society



The Royal Life Saving Society UK (RLSS UK)

The Royal Life Saving Society UK is a registered charity with a vision 'To safeguard lives in, on and near water'.

We are the governing body and leading provider of training and education in lifesaving, lifeguarding, water safety and life support skills in the UK. Our mission is 'To inform and educate everyone in water safety and resuscitation and to increase progressively the number of people trained in water rescue.'

Each year over 10,000 volunteers train approximately 1 million people in water safety, rescue techniques and life support, including 95% of all pool and beach lifeguards.

Our work includes:

- Beach and Pool Lifeguard training and qualifications
- Save a Baby Classes for parents or guardians of young children in what to do in an emergency when an infant chokes, stops breathing or drowns
- Watersafety classes that deliver key messages on safety in, on or near water especially in the National Curriculum
- Community Lifesupport classes teaching basic resuscitation as 9 out of 10 people do not know what to do in an emergency
- Junior Rookie Lifeguard and Youth Development Programmes
- Lifesaving Sport in pool and beach environments for all abilities
- Volunteering delivering key skills in the community

Founded in 1891 the Society has more than 11,000 members in 50 branches and 3,000 active lifesaving and lifeguarding clubs and Approved Training Centres throughout the UK and Ireland.



Supporters of the Life Changing Event DVD

We are grateful to the following organisations for their support in the making of this DVD.



Walker Morris is a unique legal firm with a national reputation for strong multidisciplinary teamwork and straightforward advice.

Jeanette Harwood worked with IQL UK as a consultant throughout the development of the National Pool Management Qualification (NPMQ) and Jeanette heads the Regulatory Team at Walker Morris Solicitors.

She has lectured widely on corporate governance and crisis management to bodies including the Institute of Safety and Health, Salford University and the Institute of Chartered Accountants.

Jeanette has been published extensively in the leisure press with regards to legislative matters, specifically Gross Negligence Manslaughter and the Corporate Manslaughter and Corporate Homicide Act 2007 and has also delivered numerous lectures within the Leisure Industry for IQL UK and the ISRM.

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For further information on our services please contact us on: + (0)845 8620040 or email info@poolsafetyco.com

Web site: http://www.poolsafetyco.com/

Production

This DVD was developed from an idea by Douglas Tapp, Principal Consultant at QLM Ltd.



QLM is a thriving and respected sport and leisure management consultancy company, specialising in the principles and practices of operations, management of quality, health and safety and continuous improvement. The company was formed in 1990 by its current Managing Director Peter Mills.

QLM is a wholly owned subsidiary of PHSC Group PLC.

The QLM team are regularly contracted to provide expert advice and testimony on health and safety issues within Sport and recreation Management.

Further information on QLM can be found at www.qlmconsulting.co.uk or telephone 01451 861084.