02 December 2024

Official information request 8140014863
(Please quote this in any correspondence)

Scott
By email: fyi-request-29093-62321794@requests.fyi.org.nz

Tēnā koe Scott

Local Government Official Information and Meetings Act 1987

Re: Glenfield Pools Near drowning Incident 23 June 2020

Thank you for your email dated 06 November 2024, in which you requested information about the report in respect to the near drowning of Hamish Jamieson on 23 June 2020 at Glenfield Pools. The specific details of your request and our response are below.

I requesting information held in the report provided to Auckland Council dated 30 November 2020 in respect to the near drowning of Hamish Jamison on 23 June 2020 at Glenfield Pools.

This report contained;

- The report listed 12 underlying causes that contributed to Jamieson's experience. Please provide the reports 12 underlying causes

- The report made 23 recommendations to improve safety. Please provide the reports 23 recommendations to improve safety.

Near-drowning incidents whilst not frequent, do happen. On 23rd June 2020 a customer, Hamish Jamieson entered the Glenfield Pool and Leisure Centre (GPLC) main swimming pool and practised underwater breath holding on three occasions in close succession. After submerging for the third time Hamish lost consciousness and did not surface from the pool. Hamish was rescued and received medical attention by GPLC staff. Upon arrival emergency services then undertook care of Hamish. We are pleased that Hamish went on to make a full recovery and thank those who responded with professionalism and care.

Given the severity of the incident, a comprehensive investigation was conducted, the purpose of which was to identify facts and discover how pool staff work was really done and to determine the cause(s) of the incident to understand how and why the incident happened. The investigation followed the principles of the United Kingdom's Health and Safety Executive workbook HSG245: Investigating accidents and incident. The intent of the investigation was to improve the health and safety management system to prevent a future similar recurrence. The investigation did not establish blame or liability.

This investigation found twelve underlying causes that contributed to the incident and made 23 recommendations outlined below, all identified areas for improvement were subsequently addressed.

Our teams consistently uphold the highest safety standards and are trained to respond promptly whenever assistance is required. To ensure this, our staff undergo rigorous training, strictly adhere to proven industry protocols, and enforce safety rules consistently. These measures are in place to create a secure and reliable environment for everyone to enjoy

The 12 underlying causes from the report were;

1. The gaps in and between the Job Safety Analysis being used as the only risk assessment tool demonstrates that there is an absence of robust risk management to ensure that all practicable steps have been taken to eliminate or minimise the risk to health and safety, so far as is reasonably practicable.

2. The highest level of protection against harm from hazards and risks was not suitably considered when making procurement decisions. An understanding of the requirement for a tall lifeguard chair that would allow effective supervision of the pool from an elevated position should have been obtained prior to deferring the order.

3. There is an absence of full-time experienced aquatic technical expertise and supervision at GPLC as the immediate supervision of lead lifeguards is undertaken by the Centre manager who is not an aquatic specialist.

4. The lifeguard team leader position is vacant. This is a key supervisory position.

5. Lifeguard manning levels are low with a shortfall of 40 – 60 hours per week. This places undue pressure on the remaining lifeguards, aquatic supervision and Centre management.

6. Management had not ensured that the 3 lifeguards on duty had signed a local form confirming that applicable safety documentation had been read.

7. The poolside lifeguards were distracted due to a lengthy conversation with each other; they were ineffective in their scanning and supervision of the pool and had low alert levels partly as a result of the pool being quiet and nearing closing time.

8. Refresher training on documented procedures does not occur.

9. The poolside lifeguards made an error of judgement when they chose not to immediately intervene when informed that the casualty was holding their breath underwater. They did not recognise the seriousness of the situation.

10. Job Safety Analysis documentation did not identify a risk of drowning from breath-holding.

11. Pool users are not informed via any means of the ‘Pool user code and patron rules’. It is imperative that customers are informed of the expectations required of them.

12. There are routine violations as Normal Operating Procedures are not adhered to due to ineffective supervision and management oversight. The congregation of lifeguards at lifeguard position 1 has become habit and normalised. Active patrolling should be

carried out, and lifeguards have different views of enforcing the ‘Pool user code and patron rules’.

The 23 recommendations to improve safety from the report were;

1. Acknowledge and praise the GPLC team emergency response to the incident, and in particular to those that administered emergency first aid.

2. Ensure the highest level of protection against harm from hazards and risks is suitably considered when making staffing and procurement decisions.

3. Senior management exercise due diligence to take reasonable steps to verify that suitable processes are implemented and are effective to eliminate or minimise risks to health and safety so far as is reasonably practicable, including research and review of additional controls that become available.

4. Develop and implement ‘Behavioural Based Safety’ into normal practices. This approach promotes interventions that are people-focussed and incorporates one-to-one or group observations of employees performing routine work tasks and providing timely feedback on safety-related behaviour.

5. Carry out a risk assessment of the aquatic facility that considers how lifeguards are deployed (e.g. Static in high chairs or patrolling the poolside) and their ability to see someone getting into difficulties and being able to respond in a timely manner.

6. Consider and evaluate the use of technology to aid observation of the aquatic facility such as a convex mirror at the dive well.

7. Consider and evaluate the implementation of a drowning detection system.

8. Determine the requirement for the use of CCTV and ensure any requirements are met with consideration to image quality, coverage, and back-up of footage.

9. Provide suitable equipment as determined by the risk assessment of the aquatic facility.

10. Ensure risk assessments consider hazards identified in the Normal Operating Procedures Manual.

11. Review how control measures are monitored to ensure they remain suitable and are effective.

12. Review the Normal Operating Procedures Manual to ensure it provides clarity on lifeguard positioning.

13. Review the format of the Job Safety Analysis document to align with the requirements of Corporate Standard 3 – Risk Assessment and validate the use of the scoring system and Matrix.

14. Review the lifeguard allocation and supervisory structure to ensure it is fit for purpose with consideration of supervisory management training.

15. Implement a system that regularly ensures that the emergency first aid equipment is maintained and ready for immediate use.

16. Include the use of mouth-to-mouth resuscitation facepieces in the lifeguard training Programme.

17. Include Normal Operating Procedures in the lifeguard training programme.

18. Inform and instruct lifeguards of ‘Shallow water blackout’ and the dangers of breath holding and how to prevent pool users from breath holding.

19. Inform pool users of ‘Shallow water blackout’ and the dangers of breath holding. Website information, notices and signs, and oral reminders where necessary by lifeguards should be considered.

20. Inform pool users of the ‘Pool user code and patron rules’. Website information, notices and signs, and oral reminders where necessary by lifeguards should be considered.

21. Inform, instruct, and train GPLC on emergency exit procedures that includes disabling of alarms.

22. Ensure all staff are informed and instructed on the safety documentation system.

23. Share the investigation findings across all Pool and Leisure Centres.

The decision by Auckland Council to release the information contained in this response was made by Claire Stewart, Interim General Manager Pools and Leisure.

You have the right to complain to the Ombudsman if you believe we have not responded appropriately to your request. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

If you have any further queries, please contact me on 09 301 0101 quoting official information request number 8140014863.

Ngā mihi

Amanda Pillay
Privacy and Official Information Business Partner
Customer Experience and Digital Services