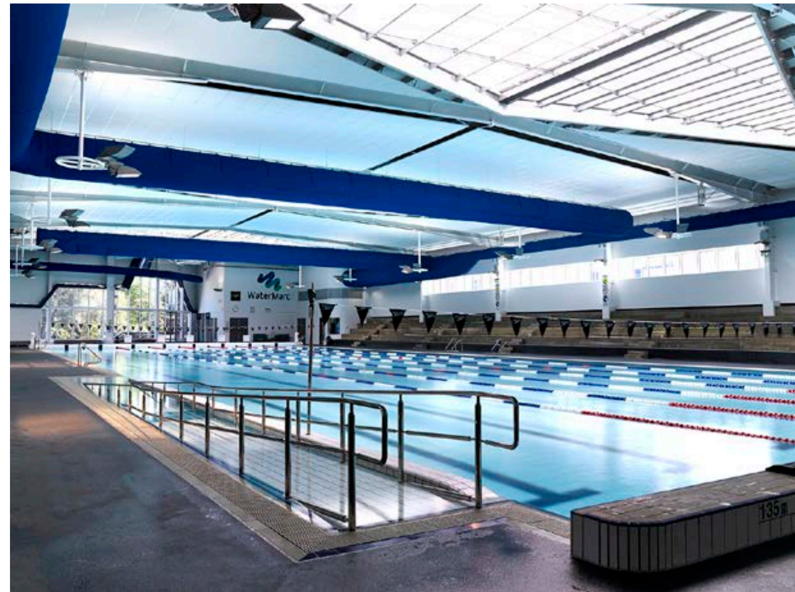
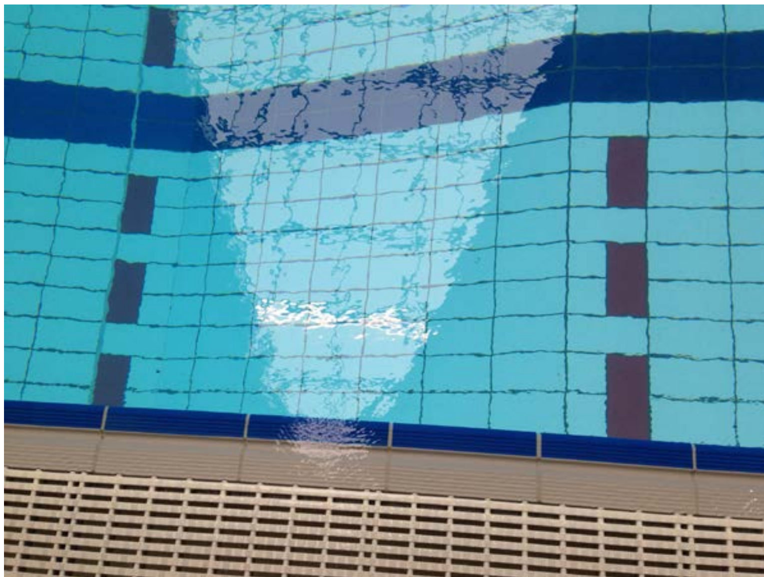
WaterMarc Case Study

The Day – Sunday 2nd February 2014

- Approximately 7:30pm
- "Gary, it's Dave here, I've just had a call from the DM………"
- Hot Day 40c plus
- 3,900 visits across the day
- 200-250 swimmers at time of incident
- 7 Lifeguards on duty with 1 Duty Manager supervising
- 3 additional staff – Reception and Health Club

The Incident Summary





Banyule
CITY COUNCIL

belgravialeisure

The Incident Summary

- Male and Female rescued - 50m pool
- Staff performed CPR
- Revived on the scene by staff and paramedics and transported to hospital
- Virajitha Kelangi survived and has made a full recovery
- Paul Rayudu passed away one week later

Incident Response

- Paul and Virajitha were pulled from the water with the help of patrons
- CPR performed simultaneously by lifeguards with assistance of patrons
- Staff evacuated entire facility
- Paramedics arrived within a few minutes and went straight to Paul
- Virajitha - breathing and heart rate returned, but remained unconscious
- Paramedics revived Paul's heart but breathing was assisted and he was unconscious
- Transported to hospital

Immediate Communication Plan

- Everyone should have their own plan to escalate information. Ours followed this path:
  - Duty Manager contacted Operations Manager
  - Operations Manager contacted Centre Manager
  - Centre Manager contacted Regional Manager
  - Centre Manager contacted Council Contract Manager
  - Regional Manager contacted General Manager
  - General Manager contacted Acting CEO
  - Customer Service contacted CS Manager
  - CS Manager handled all early queries

The Days After……..

- Briefing Staff re Media/Social Media
- Staff/Parents Welfare – short, medium and long term
- Investigation/Reporting – incident reports, further interviews, review of qualifications, manuals
- Visits from WorkSafe
- Visits from Police
- Meetings with Banyule City Council (BCC)
- Updating Stakeholders regularly

The Days After and Beyond

- Managing the incident was all consuming
- Detailed Incident Report for Police, BCC and BL
- Operational Review of Incident
- LSV Critical Incident Review and Recommendations
- Review of systems
  - Safe Work Method Statements
  - Operational Manuals
  - Area Handbooks for staff
  - Risk Assessments
  - Staff Trainings/Induction
- Crowd control investigation

Unexpected Challenges

- Who was injured?
- Getting Updates
  - Police are not providers
  - Police are Black and White
- Witness Information
  - Who saw what happened?
  - Who assisted?
  - Do we speak with or attempt to speak with?
- Different Versions of Events
- Media and Social Media

Staff Welfare

- Traumatic plus – keep updated
- Staff Debrief immediately and removed from shifts for the following couple of days
- Trauma Assist Counselling next day - Group session
- Individual Trauma Assist
- Spoken to prior to commencing first shift to see how they were going. All returned within the week
- A second group session was arranged following the passing of Paul
- External Counselling
- Offer of assistance from BCC

Staff Welfare continued

- Parents of younger staff
- “No Blame Approach” to review
- Dealing with the inconsistencies
- Shadowed the DM with another DM on first 2 shifts in case he wasn’t coping
- Continue to keep in touch with these staff to ensure they are coping
- Inquest investigation – trigger point
- Staff supplied with legal representation

Media / Social Media /PR Impact

- TV/Radio/Newspapers/Social
  - Your Policy
- Requests for comment were frequent
- Initially ‘no comment’, BCC advised and dealt with media
- Media Advisors
- TV, Radio and Newspapers ran with it early
- Social Media – persistent and varied-joint responses BCC/BL
- Challenge of meeting the public’s need for immediate feedback and response
- Frequent reviewing key with smart measured response
- PR – ‘Oh, that’s the place, where those people drowned’

Media / Social Media Impact

THE AGE WEDNESDAY, FEBRUARY 5, 2014

8 | NEWS

Swimming Regulations not enforced

Pool incident sparks safety investigation

Mr Dennis said WaterMarc, where the two students were injured on Sunday, had "always gone above and beyond" to implement recommendations made by LSV and had a strong record of meeting safety needs.

Victoria's WorkCover Authority, which has the power to check that workplaces are safe for the public, as well as for workers, visited WaterMarc soon after the incident. A spokesman says the authority was "satisfied that appropriate safety measures were in place and no further inquiries will be made at this time".

Did you witness the accident? Contact our newsroom

"They had the appropriate equipment and training ... and gave those people every chance of survival ... they did well," said Ambulance Victoria's general manager Graeme Parker the next day.

Emergency Service Communications

- Response time fantastic
  - Fire Service
  - Ambulance/Paramedics
  - Police – Not a news service
  - Hospital - Lockdown
- First Comments
  - Fire service – 'Clash of heads'
  - 'No Witnesses' – Herald Sun
  - 'Swimming Regulations Not Followed' – Age – LSV/Andy
- Ambulance praise – 2 rescues

WaterMarc Operational investigation

- A comprehensive review of all aspects of operation on the day
- Piecing together the timeline of events
- Staff qualifications and training
  - Were they qualified?
  - Were they inducted?
  - Had they been provided ongoing training?
- Staff provision and service
  - Compare to GSPO and contract
  - Ratios / locations
- Customer activity study for the day in question
- Equipment audit
- LSV Critical Incident Review

WaterMarc Operational/Procedural Changes

- Audit of Safety/First Aid Equipment
  - Spare defib pads, child pads and woolen blanket added
  - Spare oxygen and defib relocated to LG Station
- Review of SWMS
  - LG Supervision and LG Rotations with improved maps
  - Company wide introduction of improved lifeguard deployment plan
- Review Staff Induction/Qualification
  - Introduction of online system for rostering and completing new staff ‘paperwork’
  - Improved checking process
  - Increased opportunity for LG scenario training

WaterMarc Operational/Procedural Changes

- Reviewed Facility Risk Assessment Process
  - Expanded Risk Assessments
- Reviewed Boom Movement SWMS
- Improved DM Open and Close Checklists
- Emergency Action Plan
  - Reviewed with input from all department areas

Facility Upgrades

- Full Audit of PA System
  - Purchase of Megaphone
  - Worked with BCC on PA system audit
  - Full upgrade to Aquatic PA
- Automated People counter
- Signage
  - Additional signage 50m Pool, Drop Off
- Drop Off Exclusion Zone
  - Physical barriers when Aquaplay lanes operating

Coroners Inquest

- First challenge – drawn out process
- Feb 2014 - Incident
- Nov 2014 - First Coroners Directions Hearing
- May 2015 - Coroners Inquest
- July 2015 – Final submissions
- Today – still awaiting recommendations
- Staff anxiety heightened with each of the dates above

Coroners Inquest continued…

- The Inquest – 5 days
- Who was present?
- Order of witnesses
- Knowledge of industry
- Role of Counsel assisting
- Media presence
- The subplot surrounding our lack of acknowledgement to those assisting
- My time in “the box”
- Supporting staff
- Dialogue with Council – partnership approach

Summary of Learnings to Date

- Opportunity to improve
- Resource dependent (council and operator)
- Cost (council and operator)
- Managing media and social media
- Support to staff

- **From the Coroners Inquest:**
- Identification of non swimmers
- Servicing non swimmers
- Communication with non-English speaking customers
- LG Ratios??

Thank You ………. Questions?