

SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT DUNDEE

[2016] FAI 3

B87/15

DETERMINATION

BY

SHERIFF L A DRUMMOND QC

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND)
ACT 1976

into the death of

MICHAEL CHARLES GARDEN MCDONALD

Dundee, 7 December 2015

The Sheriff having considered the evidence presented, determines in terms of section 6(1) of the Fatal Accidents and Sudden Deaths (Scotland) Act 1976 as follows:

- (1) In respect of paragraph (a), Michael Charles Garden McDonald, born 28 December 1937, formerly of Newport-on-Tay, Fife, died on 25 November 2011 at 12.12 hours at Ninewells Hospital, Dundee.
- (2) That in respect of paragraph (b), the cause of death was drowning. The cause of the accident resulting in death is unknown.
- (3) In respect of paragraph (c), a reasonable precaution whereby the death might have been avoided is the provision of constant poolside supervision.
- (4) In respect of paragraph (d), there were no defects in any system of working which contributed to the death or accident resulting in the death.

(5) In respect of paragraph (e), had a more detailed consideration of the pool been undertaken by Dundee City Council prior to the accident, the nature and depth of the pool and the lack of constant poolside supervision could have been established and addressed at an earlier stage.

NOTE

Introduction

[1] This is a fatal accident inquiry in terms of section 1(1)(a)(ii) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 inquiring into the death of Mr Michael Charles Garden McDonald.

[2] The Crown were represented in the public interest by Mr Gavin Callaghan, Senior Procurator Fiscal Depute; Hilton Hotels were represented by Mr Barry Smith, Advocate. Mr Peter Watson, solicitor-advocate, appeared on behalf of Dundee City Council. Mr McDonald's family were not represented.

[3] I heard evidence over seven days on 15, 16, 17, 18, 23 and 24 June and 4 August 2015. I heard evidence from the following witnesses:

- 1 William Henry Andrew Tanner, former Living Well Club Member
- 2 Margaret Dempster, Duty Manager, Hilton Hotels
- 3 Peter Alder, fitness adviser, Living Well Club
- 4 Jaclyn Jamieson, receptionist, Living Well Club
- 5 Elizabeth May, member carer, Living Well Club
- 6 Inspector Frank McManus

- 7 Dugald Emans, environmental health officer, Dundee City Council
- 8 James Spence, Hilton Hotels
- 9 Largue Morrison, Hilton Hotels
- 10 Jennifer Newcombe, manager, Living Well Club

The following expert witnesses were led by the Crown:

- 11 Dr Barry Klassen, Accident and Emergency Consultant, Ninewells Hospital
- 12 Dr Clare Brown, General Practitioner
- 13 David Sadler, senior lecturer in Forensic Pathology
- 14 Peter Mills, expert in swimming pool safety

Hilton Hotels led the following expert witness:

- 15 Jacqueline Gawen, health and safety consultant

[4] In addition parties agreed a number of matters in a joint minute of agreement.

Five volumes of productions were lodged by the Crown though not all referred to at the inquiry. Draft written submissions were exchanged and final submissions lodged on 4 September 2015.

Legal framework

[5] The parties appeared to agree about the legal framework within which the determination should be made. The inquiry is not the proper forum for determination of

civil or criminal liability. Nor is it the proper forum to make any finding of fault or to apportion blame (*Black v Scott Lithgow Ltd* 1990 SC 322 at 327 per Lord President (Hope)). In reaching my determination I must address the matters set out in section 6(1) of the 1976 Act. Any finding under section 6(1)(c) should avoid, so far as possible, any connotation of negligence or contain any indication of whether a person was under a duty to take the reasonable precaution identified in the finding (Determination of Sheriff Principal Mowat QC in the Lockerbie Inquiry (quoted with approval by Sheriff Principal Lockhart in the Rosepark Inquiry)). The statutory provisions are intended to permit retrospective consideration of the matters with the benefit of hindsight and on the basis of the information and evidence available at the time of the inquiry. The purpose is to look back, as at the date of the inquiry, to determine what can now be seen as reasonable precautions, if any, whereby the death might have been avoided, and any other facts which are relevant to the circumstances of the death. The purpose is to assist those with an interest to take steps to prevent such a death recurring in the future.

[6] In relation to making a finding under section 6(1)(c), it is not necessary to be satisfied that the proposed precaution would in fact have avoided the accident or death, only that it might have done. However, the court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one. The phrase “might have been avoided” is a wide one which means “less than would on the probabilities have been avoided and rather directs one’s mind in the direction of the lively possibilities”. There requires to be a “real and lively possibility” that the death might have been avoided (*Carmichael on Sudden Deaths* and

Fatal Accident Inquiries 3rd Edition, paragraph 5-75). An appreciation of the foreseeability of the risk does not form part of the exercise. Nor is it the function of the inquiry to determine whether any reasonable precaution should or could have been recognised and implemented: the statutory provisions are concerned with the existence of reasonable precautions or defects in the system at the time of the accident or death. (Determination of Sheriff Principal Lockhart, “Rosepark Inquiry”, Hamilton Sheriff Court, 20 April 2011).

[7] In deciding whether to make any determination under section 6(1)(d) of the 1976 Act as to the defects in any system of working which contributed to the death or to any accident resulting in the death, the court must, as a precondition to making any such recommendation, be satisfied that the defect in question did in fact cause or contribute to the death (paragraph 8-99, Carmichael).

Where and when the death and any accident took place

[8] Mr Michael McDonald was born on 28 December 1937 and at the date of his death resided at Newport-on-Tay, Fife. In 2011, Hilton UK Hotels Limited (“Hilton”) operated a hotel and Livingwell Health Club (“the Livingwell”) at Earl Grey Place in Dundee. Mr McDonald was a long-standing member of the Livingwell and attended on a daily basis for seven years. In 2006 he was diagnosed with Parkinson’s Disease and staff had noticed a decline in his health prior to his death. The Hilton hotel and the Livingwell in Dundee have subsequently been demolished.

[9] There did not appear to be any significant dispute in fact as to what occurred on 25 November 2011. I heard evidence about that from Mr Tanner, Mrs Newcombe, Mrs Dempster and Mr Alder, employees of Livingwell. Mrs Newcombe arrived at the Livingwell that day between 6am and 6.15am when Mr McDonald was already there. Mrs Newcombe was responsible for the pool that morning. She was on duty at reception along with Mr Alder who was due to take a spinning class. She recalled that Mr McDonald had first used the gym that morning, something he hadn't done for a long time. He had then changed out of his gym clothing and entered the pool. Mrs Newcombe was able to watch him enter the pool from where she was standing at the reception desk through a glass partition. Mr McDonald was within her eyesight although she was not constantly watching him as she was attending to others at reception. At one point Mrs Newcombe noticed Mr McDonald had exited the pool to go to the bathroom and then re-entered the pool. He had been swimming the breast stroke. He had an unusual style of breaststroke where he was submerged in water longer than usual. Shortly after she last saw Mr McDonald, another Livingwell member, Mr Tanner, was returning along the corridor alongside the pool towards reception. When Mr Tanner looked through the glass partition into the pool he could see someone at the bottom of the pool and in the middle of the pool where it is deepest. The person was lying face down and was not moving. Mr Tanner alerted Mrs Newcombe by shouting to her. Mrs Newcombe was standing at the reception desk with Mrs Dempster. According to Mrs Newcombe she estimated the last time she had seen Mr McDonald in the pool was a couple of minutes or a maximum of 5 minutes before Mr Tanner alerted her. Mrs

Newcombe turned to the pool and saw that Mr McDonald was lying at the deepest point. He wasn't moving at all. Mrs Newcombe had been trained in pool rescue. She dived into the pool fully clothed and brought Mr McDonald to the poolside. She gave him one resuscitation breath in the pool and cardiopulmonary resuscitation (CPR) at the poolside. In the meantime, Mr Tanner fetched Mr Alder who attended at the poolside to help. Mr McDonald started to breathe again but did not gain consciousness. Mrs Dempster called an ambulance. Her emergency call was received at 0738 hours and an ambulance arrived at 0746 hours. The ambulance left at 0801 hours and arrived at Ninewells Hospital ("Ninewells") at 0808 hours.

[10] At Ninewells, Mr McDonald was seen by Dr Barry Klassen, Accident and Emergency Consultant, who was aware that Mr McDonald had been retrieved from the pool. Mr McDonald's temperature, consciousness, blood pressure, heart rate, oxygen saturation levels and breathing were assessed. He had cardiac monitoring by electro cardiogram to measure electrical activity across the whole of his chest. He had abnormal breathing patterns and was assisted in breathing by bag and mask on arrival. His pulse rate was a little elevated though not abnormally fast. His blood pressure was also elevated but reasonable. He had good peripheral pulses but was deeply unconscious. He was provided with full advanced life support. Despite breathing, his oxygen was not saturating sufficiently. Taking account of the report of what had happened to Mr McDonald at the Livingwell and that Mr McDonald had a history of high blood pressure and hypertension, Dr Klassen suspected something may have gone wrong with Mr McDonald's heart or brain. However, the ECG indicated that all

chambers of his heart were beating in the normal way. There were no signs of weakness of face or arms or legs on presentation indicative of a stroke. A brain scan was undertaken which showed no bleeding in his brain. Although Mr McDonald was breathing, he wasn't maintaining his oxygen levels or blood pressure and remained deeply unconscious and unresponsive. He deteriorated and further intensive care was deemed futile. McDonald died at Ninewells at 1212 hours on 25 November 2011.

The cause of death and any accident resulting in death

[11] Mr McDonald's body was examined by Dr Graham Whyte, forensic pathologist, on 1 December 2011. The post mortem report is produced at CP 2. Sadly, Dr Whyte died in 2015. Dr Whyte's colleague, Dr Sadler, forensic pathologist, attended the inquiry instead. Dr Sadler confirmed that the cause of death was drowning as recorded in the post mortem report. Dr Sadler explained that there was nothing of concern on examination of Mr McDonald's heart, brain and blood. There were no marks or injuries of any concern. What was found was entirely consistent with the degree of medical intervention Mr McDonald had received at Ninewells. His heart was a normal shape and size. His coronary arteries showed very little sign of narrowing for a man of 73 years of age. His heart reflected a healthy lifestyle. The lung airways were unobstructed and free from disease and had no fluid present. The lungs were heavy with fluid and congestion as would be expected when a person has died of drowning and had subsequent heart failure. On examination of the cranium and nervous system, they also showed no aneurisms and were similarly undiseased and relatively good for a 73 year

old man. His brain showed no sign of a stroke. In the circumstances the conclusion drawn was that Mr McDonald's death by drowning was purely accidental in the absence of natural disease.

[12] Dr Sadler also explained in evidence that drowning is complex. A person drowns not just because a body is immersed in water and cannot breathe. The lungs absorb water from the airways into the blood circulation. The circulation expands with more fluid circulating in the bloodstream and the normal salts in the blood become diluted. A low sodium count in blood is very damaging to the heart. Ultimately heart failure will result. Normally death will occur within minutes. The sooner a person is removed from the water, the better the prospects of survival. There is a short period of time within which a person will be amenable to resuscitation. There is an interval of between 2 to 3 minutes where the person can be revived but brain damage subsequently kills them. Dr Sadler's opinion was that Mr McDonald was caught just on the cusp of death and was resuscitated but that brain damage had already occurred. He subsequently died as a consequence of that brain damage. Dr Sadler explained that the length of time a person might survive may depend on their physiological reserve: a young person with better lung function and heart flow may survive longer than a more elderly person whose functions have become gradually impaired with age. Given Mr McDonald's age he would be expected to be at the lower end of the time range for recovery. Had he been left any longer in the water, Dr Sadler was of the view that it is unlikely he would have been resuscitated.

[13] According to Dr Sadler, the degree of change in Mr McDonald's lungs suggested that he had inhaled water and drowned. Nothing found at the post mortem examination could shed light on what precipitated him to inhale water. The post mortem had excluded heart disease or cerebral disease. If looking for a natural event that may have precipitated the inhalation of water, Dr Sadler indicated that the fact that Mr McDonald suffered from Parkinson's Disease is higher on the list than any other factor. His difficulty in initiating movement as a result of Parkinson's Disease may have made him slow to react to gulping water. An arrhythmia or transient ischaemic attack may have occurred but the post mortem examination would be unable to determine if that had occurred as neither leave physical signs at autopsy. Once in the water and swimming established Dr Sadler was of the view there was less likelihood of an arrhythmia occurring although a syncopal episode (faint or blackout) would be more likely. However, there was no way of refuting or proving that Mr McDonald may have suffered a blackout. If a person swims under water, it is more likely to place them in difficulty if they suffer a blackout. A natural reaction if a person gets into difficulty is to put their feet down to regain composure but it may have been given his slowness to react Mr McDonald was not able to do that. Dr Sadler recognised that there may well have been no outward sign of Mr McDonald getting into any difficulty.

[14] I heard evidence about Mr McDonald's health from his GP, Dr Clare Brown. Mr McDonald was a patient of Dr Brown's from 2007. Dr Brown saw Mr McDonald regularly. She described Mr McDonald as an outgoing, self-disciplined and driven individual whose exercise routine was very important in his life. He was remarkably fit,

going to the gym on a daily basis and playing tennis. Mr McDonald had a history of chest pain when he ran which was suggestive of angina and for which he was prescribed medication. He had tests in 1994 and was referred to a cardiologist. These were negative but given his history he continued with the medication. He had high blood pressure dating back to the 1980s and was prescribed medication for that too.

[15] In 2006 Mr McDonald was diagnosed with Parkinson's Disease. Dr Brown explained that Parkinson's Disease is a neuro-degenerative disorder where cells, which are essential for the nerve pathway from brain to muscle, die and affect a person's movement. Mr McDonald had reported a slight tremor just as he was going to initiate movement. He also reported excessive salivation. He had slight reduced facial expression. He subsequently developed a more obvious tremor in his left arm and in his leg. He found it particularly difficult to initiate movement such as rising from a chair. By 2009 his symptoms appeared to be very well controlled. However, by 2011 he was described as suffering from quite significant Parkinson's disease: he needed to rock in the chair in order to lever himself out of the chair and his posture had become more stooped. In the few months before his death, there was a definite change in his health with a very definite progression of the disease and more reduced mobility. He had also developed cellulitis, infecting and swelling his lower leg which had given him recurrent problems with mobility. His movement was slower and his ability to start moving was significantly reduced. His tremor and stoop were more pronounced. Whilst it took Mr McDonald longer to initiate movement, Dr Brown had never seen him freeze with movement once he was up and moving. His voice was slightly reduced but mentally he

was unaffected. He had been assessed by DVLA in 2010 as fit to drive. His exercise regime was likely to be helpful to maintain as much muscle strength as possible although it was unlikely to slow down the progress of the disease. Mr McDonald had never displayed any symptoms of arrhythmia. He had an ECG which displayed a regular heartbeat. He at no point displayed any symptoms that suggested he had suffered a transient ischaemic attack or a blackout.

[16] I was invited by the Crown to find that the cause of the accident relating to the death of Mr McDonald was *“that for reasons which are not certain, but which may have been connected to the effects of Mr McDonald’s Parkinson’s disease, he went under water, and was not able to recover the situation in the way that someone not physically inhibited may have been able to. Mr McDonald was thereafter under water for an unknown period of time, likely to have been around a couple of minutes or thereby, the swimming pool there not being the subject of constant poolside supervision.”* Mr Smith and Mr Watson invited me to conclude that the cause of what brought about the drowning is unknown.

[17] From the above evidence I formed the view that although the undisputed evidence is that Mr McDonald died from drowning, what precipitated Mr McDonald to inhale water and be unable to recover is uncertain. I accept the uncontested evidence of Dr Sadler that an arrhythmia, a Transient Ischaemic Attack (“TIA” or “mini stroke”) or a syncopal episode (faint or black out) could have occurred without leaving any signs at post mortem. None of these possibilities could be excluded from having occurred. Although Dr Sadler considered that Parkinson’s Disease was higher on the list of possibilities than any other event, since Mr McDonald’s difficulties in initiating

movement might well have made him slower to react to swallowing a mouthful of water or to recover, he could not say that was the cause of the accident causing drowning. He could not exclude any of the other medical reasons. I do not consider that Dr Sadler's evidence would allow me to draw an inference on the balance of probabilities that Parkinson's disease was the cause of the accident. I did not understand Dr Sadler's views to come anywhere near supporting such a proposition. Parkinson's disease was simply higher on the list of possibilities but he made it clear there were a number of other possibilities which could not be excluded and could have occurred without leaving any trace at post mortem. Nor was I able to draw any inference as to why or how Mr McDonald got into difficulty from the fact he was found at the bottom of the pool and the deepest point: there is no evidence about how he ended up in that location in the pool and it seems to me the very fact he ended up there says nothing about what caused him to be there. Although Parkinson's may be higher on the list of probabilities, I am not satisfied that the evidence establishes that to be the cause on balance of probabilities. There is a real possibility that the cause of drowning was something unconnected to Parkinson's Disease. I therefore conclude that the cause of the accident leading to the death is not known.

The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided

[18] I was invited by the Crown to conclude that had constant poolside supervision been provided at the Livingwell, and had Mr McDonald been spotted and rescued from the bottom of the swimming pool more quickly, his death might have been avoided. The

Crown submitted that although the possibility of Mr McDonald suffering brain damage could not be ruled out, Mr McDonald had been on the cusp of death when he had been retrieved from the pool. Had he been reached more quickly, there was a lively possibility that his death might have been avoided. On behalf of Hilton, Mr Smith invited me to find that it is a matter of speculation whether a lifeguard would have recognised the need for intervention earlier than Mrs Newcombe did and it is unknown how long Mr McDonald could have survived underwater before death followed. He also invited me to conclude that even if the inquiry was satisfied that the presence of a lifeguard might have avoided the death, constant poolside supervision was not a reasonable precaution. Mr Watson submitted that given it is not known what event caused Mr McDonald to drown, it is impossible to know what, if any, reasonable precautions could have been taken to avoid the death. I consider first whether constant poolside supervision is a precaution that might have avoided McDonald's death and second whether that was a reasonable precaution.

[19] It is essential in addressing these questions to understand the arrangements for supervision that existed at the Livingwell in 2011 as well as the physical design of the pool. There was not any significant dispute in evidence about these matters. Supervision of the pool was carried out from the reception desk which was located in a corridor leading down to the gym. There was a glass partition immediately adjacent to the pool which separated the pool from the corridor and reception desk. A glass door led directly into the pool from the reception desk. The glass partition and door was partially frosted.

There was separate direct access to the pool from the changing rooms. On the south side of the pool, large windows ran the entire length of the pool, overlooking the River Tay.

[20] The pool was usually supervised from the reception desk by two people. While at the desk staff were required to attend to other tasks such as swiping in members and guests on arrival. All Livingwell staff had first aid and pool rescue qualifications. Staff were required to ask new members to complete a questionnaire to identify certain medical conditions. On occasion, the staff were also required to leave the desk to attend to various other tasks. One of those tasks was to conduct hourly patrols of the swimming pool. There were varying accounts as to how long the desk was left unattended from about a couple of minutes and possibly longer including periods when the pool was in use. On the rare occasions when a member of staff was alone on the reception desk and required to take a break, staff from the hotel would cover for them.

[21] Although when standing behind the reception desk staff were facing away from the pool, staff gave evidence that they were able to position themselves in such a way that they could see the whole of the pool. However, there were differing accounts from the witnesses as to whether or not the frosting on the glass partition and door affected the view from the reception desk. Ms Jamieson suggested it did affect the view but it was only a matter of stepping back to see fully. Mrs Newcombe indicated the frosting was never an issue. She was taller than the frosting on the door as were the majority of staff and she was able to see the whole of the bottom of the pool from her stance at the reception desk. There was a difference of opinion amongst the safety experts on the point also. According to Mr Mills, swimming pool expert, the markings on the glazed

partition could have had an impact on supervision of the pool. On the other hand, Mrs Gawan, health and safety expert, considered that the glazed partition did allow an adequate view of the pool.

[22] In addition to the view through the glass partition, staff were able to monitor the pool by viewing live CCTV footage of the pool on monitors placed on the reception desk. The CCTV provided two five second views of the pool on a 30 second cycle. The rest of the cycle provided views of the gymnasium. Some of the witnesses, including Mr Mills, stated that glare from the pool might affect the view of the pool. However, witnesses all agreed that since the accident occurred at 7am in the dark that glare was not a relevant consideration in this case.

[23] As far as the design of the pool was concerned, the evidence established that it was of a relatively unusual design described as a “hopper” shape. It measured 10 metres by 8.5 metres with a shallow depth on all four sides of 0.9 metres and a steep shelf to a central deep point of just under 1.9 metres. Access from the changing room end of the pool was via a wide set of steps. The gradient within the pool was steeper than 1 in 15 in water of less than 1.5m.

[24] I concluded from this evidence that the supervision arrangements in place on 25 November 2011 did not amount to constant poolside supervision in the sense that a lifeguard was not on constant watch of the pool. I concluded from the evidence of Ms Jamieson and Mr Mills that not all staff were able to obtain a clear view through the glass partition unobstructed by the frosting. Although Mrs Newcombe thought that was not an issue, she recognised that it would only be staff that were tall enough that would

be able to see over the frosting. The frosted glass partition had the potential to partially obscure the view when a pool attendant was looking at the pool. In any event, staff at the reception desk did not have their constant attention on the pool. They were not carrying out a 20:10 scan of a pool which Mr Mills described lifeguards are trained to carry out. Mr Mills explained that involves a ten second scan of the pool with twenty seconds to respond and reach the person in trouble. At the Livingwell, reception staff's attention was partly on the pool and partly on carrying out other tasks including dealing with members on arrival. Whilst CCTV monitors were available at the reception desk, the views on the CCTV were partly of the pool and partly of the gym. In any event, staff were not constantly watching the monitors. Although infrequent, there were periods when the desk was left unattended or staffed by an unqualified person while staff were elsewhere in the hotel. For those reasons, I do not consider that supervision from the reception desk constituted constant poolside supervision.

[25] Had constant poolside supervision been in place, could it have avoided Mr McDonald's death? Mrs Newcombe thought it had been at least a couple of minutes but no more than 5 minutes since she had last seen Mr McDonald in the water. According to Dr Sadler, Mr McDonald was on the cusp of a point of no return when he was rescued, that being within an interval of two to three minutes of having being submerged under water when his breathing could be revived but he subsequently died from brain damage. If left underwater any longer, Mr Sadler's opinion was that it is likely Mr McDonald would have been dead by the poolside. Dr Sadler explained that the period of submersion that could be endured would depend on age and physiological reserve. A

few minutes would be the maximum that could be endured although given Mr McDonald's age it was likely that the period would be closer to two minutes. The less time submerged and the sooner resuscitated the greater the likelihood of blood flow to the brain being restored.

[26] I accept Dr Sadler's evidence that it seems likely that Mr McDonald was rescued when he was on the cusp of survival i.e. in the interval of two to three minutes of having been submerged in water. Had a lifeguard been on constant watch is there a real and lively possibility that he would have spotted Mr McDonald and rescued him within that first minute or two? I take into account the evidence of Dr Sadler that there are very often no outward signs of distress or trouble at all when a person drowns. Nonetheless, as Mr Mills explained, lifeguards are trained to be on constant watch and to conduct a 20:10 scan of the pool which involves a rolling cycle of 10 seconds to scan the pool and 20 seconds to reach the person in trouble. It seems to me from the evidence, given that Mr McDonald was on the cusp of survival, that there was at least a period of two minutes where Mr McDonald must have been submerged in water before being retrieved from the pool. Mrs Newcombe had not been looking at the pool when she was alerted by Mr Tanner that there was someone lying at the bottom of the pool. She had not noticed Mr McDonald in the pool for at least two minutes. Although Mrs Newcombe responded immediately to Mr Tanner's alert, there must have been an interval of time when Mr McDonald was at the bottom of the pool and during which Mr Tanner spotted Mr McDonald, alerted Mrs Newcombe and Mrs Newcombe entered the pool area and retrieved Mr McDonald. It seems to me that, whilst there can be no certainty, there is a

real and lively possibility that a lifeguard on constant watch conducting a 20:10 scan of the pool might have been able to spot and reach Mr McDonald sooner than Mrs Newcombe was able to reach him and within those first two minutes. A lifeguard on constant watch is operating in very narrow timescales, where a repeated scan is being conducted within a single minute. I consider that there is a real and lively possibility that such a scan could have identified Mr McDonald lying at the bottom of the pool almost immediately, possibly within seconds of that occurring, and in any event within two minutes of his submersion in water. I therefore conclude that the presence of a lifeguard on constant poolside supervision might have avoided the death.

[27] Was the provision of constant poolside supervision a reasonable precaution? The question which I require to address is not whether the supervision arrangements were satisfactory *per se* nor whether they were compliant with any statutory, regulatory or common law duty, nor whether they were in accordance with HSE Guidance. The question is whether the provision of constant poolside supervision is a reasonable precaution whereby the death and accident resulting in the death might have been avoided. Mr Smith submitted that “reasonable precaution” falls to be given its ordinary meaning, which connotes balance and moderation, something which is not greatly less or more than can be expected and involves assessing the quantum of risk against the sacrifices involved in averting the risk.

[28] Many of the witnesses were asked about the policies that Hilton had in place for supervision of swimming pools. These are contained in Crown Productions 13 (wet leisure supervision policy statement), 14 (internal memo – wet leisure supervision policy

statement) and 17 (safe system of work No 13 – health club supervision). I do not repeat the terms of these here since it seemed to be accepted by all the witnesses that the supervision arrangements in place at Livingwell generally conformed to those policies. The evidence was that the industry guidance (HSG 179) (“the guidance”) was taken into account when those policies were made. Although I heard evidence at the inquiry as to whether or not the policies did properly reflect the guidance, it seems to me that it is not the role of this inquiry to conduct an examination of the adequacy of those policies in light of the guidance. What I am concerned with is whether there were reasonable precautions that could have been taken at the time of death and which might have avoided the death. In addressing that question I must assess evidence given by the safety experts led at the inquiry.

[29] Mr Mills made various criticisms of the Livingwell risk assessment (CP 16) in his report including that it did not assess the adequacy of the visibility of the pool from reception, the number of lifeguards and lifeguard safety and the lack of direct poolside supervision at all times for a hopper style pool. In his opinion had a competent risk assessment been carried out against the guidance, it is reasonable to conclude that a risk reduction measure would be to provide continuous poolside supervision. Mr Mills was of the view that since the Livingwell pool had water deeper than 1.5m and also had an abrupt change of depth in the sense that it had a steep gradient of more than 1 in 15 in water of less than 1.5m depth, constant poolside supervision was required. He reached that conclusion on an ordinary reading of paragraphs 186 and 187 of the guidance and flowchart at figure 3, which indicated that constant poolside supervision was required

or at least “*strongly recommended*” where either one of those factors was present.

According to Mr Mills, constant poolside supervision although undefined as a term in the guidance, involves a qualified pool attendant constantly monitoring the pool from the poolside and conducting a 20:10 scan involving a rolling cycle of 10 seconds to scan the pool and 20 seconds to reach the person. By scanning the pool in such a way, a lifeguard should have been able to reach someone within 20 seconds. In Mr Mills’ opinion, as an alternative to constant poolside supervision, physical alterations could have been made to redesign the pool to avoid water depth of greater than 1.5m and to eliminate the steep gradient thus removing the need for constant poolside supervision.

[30] According to Ms Gawen in her report (Hilton Production 1), it was not reasonably practicable to provide constant poolside supervision at the Livingwell. She criticised Mr Mills for interpreting the flow chart in the guidance as prescriptive. She accepted that slavish following of the guidance would require constant poolside supervision but in her view it was not reasonably practicable to have it in this case. On the meaning of “reasonably practicable” the guidance provides that the degree of risk needs to be balanced out against time, trouble, cost, benefit, and the physical difficulty of taking the measures to avoid or reduce the risk. Based on the number of users and how the pool was used, Ms Gawen was of the opinion that the pool was adequately supervised. In relation to the accident, there was a qualified pool attendant on duty at the time who responded immediately the alarm was raised and effected a rescue and administered CPR effectively. In her opinion, the pool only came under real consideration for constant poolside supervision because of its depth. The change in

gradient was a factor but was not so abrupt to require constant poolside supervision. Only a minimal water area (1.2% of the pool volume) was over 1.5 metres in depth and in her opinion that did not significantly increase the risk enough to warrant the introduction of a member of staff on poolside at all times that the pool is open. That could not be justified on the balance of costs versus risk which is the approach advocated in the guidance. In addition in her opinion how the pool was used did not identify the pool as requiring constant poolside supervision. The level of supervision in place was entirely in line with other pool operators. Ms Gawen also considered that the reason that water depth of more than 1.5 metres and steep gradients are selected as risks to bathers is identified in the guidance is related to non-swimmers or weak swimmers as they would generally not be able to stand up in deep water. However, there was no evidence in this case that the depth of the pool or the gradient of the pool caused Mr McDonald to get into difficulty.

[31] On the question of whether constant poolside supervision is a reasonable precaution, I preferred the evidence of Mr Mills to the evidence of Ms Gawan. In assessing whether a precaution is reasonable it seems to me that I can be guided by the terms of the industry wide guidance contained in HSG 179. Paragraphs 186-189 list factors to consider when deciding whether constant poolside supervision is necessary under reference to the flowchart in figure 3. The flowchart must be read in the context of paragraphs 186-189 inclusive. Paragraph 186 makes it clear that a risk assessment may determine circumstances where the balance of cost and risk make it possible to provide a safe swimming pool environment without constant poolside supervision. But the

guidance then goes on to indicate when constant poolside supervision is recommended and lists factors where the risk to safety is highest. Although guidance only, there is a strong recommendation at paragraph 187 that constant poolside supervision be provided where the pool has water deeper than 1.5 metres or has abrupt changes in gradient. The flowchart indicates that constant poolside supervision is required when either of these features are present. Both of these criteria were present at the Livingwell. The guidance does not suggest an assessment of the percentage volume of pool water deeper than 1.5 metres and makes the recommendations irrespective of the volume of pool water at that depth. I accept that other pool operators may not provide constant poolside supervision. However, what is a reasonable precaution must be assessed on its own circumstances. The hopper style pool is a relatively unusual design of pool. The physical nature of that pool with a deep central point beyond 1.5m and abrupt changes in gradient were such that it fell within more than one of the listed criteria for constant poolside supervision under the guidance. I preferred the evidence of Mr Mills that the guidance represents reasonable practice to avoid drowning. I should add that I do not accept, as submitted by Mr Smith and Mr Watson, that there was no opinion evidence as to whether constant poolside supervision was a reasonable precaution. Mr Mills' evidence was that constant poolside supervision was strongly recommended. Although he accepted there were cost implications in providing constant poolside supervision, he did not suggest that meant that constant poolside supervision was not a reasonable precaution. He was of the view that there were other means of avoiding such costs such as removing the design features of the pool which resulted in constant poolside

supervision being strongly recommended for that pool. Adopting an approach of moderation and balance, considering what it is reasonable to expect, weighing up the risk on the one hand against the sacrifices involved in averting the risk, I conclude that the precaution was a reasonable one. There were real and inherent risks in the use of the pool at the Livingwell. I do not consider that the sacrifices involved in averting that risk by providing constant poolside supervision are unreasonable or beyond what one might expect.

Section 6(1)(d): Were there any defects in any system of working which contributed to the death or any accident resulting in the death?

[32] There was no evidence before the inquiry that any defect in any system of working caused the accident resulting in Mr McDonald's death. I therefore make no findings under section 6(1)(d).

Section 6(1)(e): Are there any other factors which are relevant to the circumstances of the death?

[33] I am invited by the Crown to make findings in respect of facts which are not causative but are relevant to the circumstances of the death. In particular I am invited to make findings in relation to Dundee City Council's ("DCC") involvement with Livingwell and particularly that had a more detailed consideration of the pool been undertaken by DCC in 2009, or earlier, any issues with the supervision requirements could have been identified and indeed challenged at that time, with the option of enforcement steps having been available to DCC. Mr Watson on behalf of DCC

submitted that no criticism had been put to Mr Emans that his inspection had been perfunctory in 2009. The Crown's proposed finding should not be made as it was not based on fact or evidence adduced. There was no evidence that Mr Emans' approach departed from the recognised approved standard or approach. He proceeded on the information given to him by the employees at the Livingwell.

[34] DCC had a role in inspecting the Livingwell and legislative powers to seek, if necessary, to improve arrangements relating to health and safety. Mr Emans, environmental health officer, described the process of inspecting the Livingwell which concentrated amongst other things on inspection of the quality of water, safety aids, signage and equipment. He walked around the premises and identified matters for further investigation. He used a basic tick form as an aide memoire. A report was then completed (CP 37). He checked to see that appropriate documentation existed, but did not check the documentation itself. He knew that the documentation included the swimming pool risk assessment but did not read it.

[35] At the time of his inspection in 2009, Mr Emans was under the misapprehension that supervision of the pool was undertaken constantly from the desk which was always manned by two members of staff and never left unattended. (It was not suggested by anyone that Livingwell tried to hide the fact that poolside supervision was not constant, which was apparent from the policy documentation.) Mr Emans also explained that in 2009 he was unaware of the hopper style shape of the pool which was not a pool style he had inspected before. There was some confusion in Mr Emans' evidence as to what he had thought the depth of the pool was in 2009. Initially he stated that he had understood

that the pool was a constant 0.9m across the pool. However the following day in evidence he stated that in fact in 2009 he had understood that the pool was deeper than 1.5m and that there was a deep end. The signage implied one deep end rather than a central deep point. His view was that constant poolside supervision was required and that there was constant staffing of the desk in satisfaction of that requirement. His evidence was that he may not have been so content with the supervision had he known it was a hopper style pool and that supervision was not constant. Had he been aware of that, Mr Emans confirmed he would have questioned the risk assessment and would have taken the pool design into account as part of his inspection and findings.

[36] Since Mr McDonald's death, DCC's approach to swimming pools has changed and a far more detailed inspection pro forma is now in use (CP 31). The pro forma prompts the inspector to check the depth and gradient of the pool as well as poolside supervision. When contrasted with the pro forma used by Mr Emans in 2009, it is clear that the current approach is far more robust and detailed. There was no evidence that Mr Emans' approach in 2009 departed from the standards applied at the time. However, in hindsight, it seems to me clear that had a more detailed consideration of the pool been undertaken by DCC prior to the death, the actual physical dimensions and depth of the pool and the lack of constant poolside supervision could have been established and addressed at an earlier stage.

[37] I am also invited by the Crown to record that swimming pool operators ought to ensure that all staff who are responsible for making decisions about matters affecting swimming pool safety are sufficiently familiar with the terms of the guidance, in the

hope that such familiarity will assist duty holders in fulfilling their duties in respect of the swimming pools they operate. It seemed to me from the evidence in this inquiry that the persons who were responsible for making decisions about matters affecting swimming pool safety were aware of the guidance. I do not therefore consider it appropriate to make any finding in relation to that.

[38] I extend my sincere condolences to Mr McDonald's family for their loss.

[39] I am very grateful to all parties for the efficiency and courtesy with which they conducted the inquiry.