

**SHERIFFDOM OF SOUTH STRATHCLYDE,
DUMFRIES AND GALLOWAY**

DETERMINATION by JOHANNA JOHNSTON,
Queen's Counsel, Sheriff of South Strathclyde,
Dumfries and Galloway following an Inquiry held at
Kirkcudbright into the death of LAURA
MCDAIRMANT, aged 15 years, who normally resided
at Jesmond House, Wetheral Pasture, Carlisle.

Kirkcudbright, 24th June 2010

In view of the length of this Determination, I have set out below a list of contents by
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PART I: INTRODUCTION

- (1) This is an Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the circumstances of a death of Laura McDairmant who died in the Dumfries and Galloway Royal Infirmary, Dumfries on the 26th of July 2006 as a result of injuries sustained in a fall at Grey Mare's Tail Burn, Galloway Forest Park on the 25th of July 2006.
- (2) Mr Scott Toal, Procurator Fiscal Depute appeared in the public interest; Mr David Sheldon, Advocate, appeared for The Abernethy Trust; .Mr James Herd, Solicitor, represented The Health and Safety Executive; and Mr Bryan McLachlan, Solicitor, appeared on behalf of Dumfries and Galloway Council.
- (3) The Inquiry heard evidence and submissions for a total of 22 days in the period from 16th November 2009 to 22nd March 2010. The Crown led thirty two witnesses. The parties entered into two joint minutes of agreement. An affidavit was submitted by the Crown in respect of the evidence of Dr John Clark, Forensic Pathologist. On the 2nd of February 2010, the Inquiry attended at the Grey Mare's Tail Burn, Galloway Forest Park and viewed both pools there.

PART II: FINDINGS IN FACT

1. Background

- (1) As at 25 July 2006 Laura McDairmant was 15 years of age having been born on 16 April 1991. She normally resided at Jesmond House, Wetheral Pasture, Carlisle. Laura was a fit and healthy young woman.
- (2) The Abernethy Trust is a charitable trust, which provides outdoor education for schools and activity and adventure courses at a number of outdoor centres in Scotland. The Trust is one of the main providers of outdoor education in Scotland.
- (3) The Trust acquired the Barcaple Adventure Centre (Barcaple) at Ringford, Kirkcudbrightshire in January of 2001. Barcaple was purchased from the Tarff Trust, which had operated an Adventure Centre at that site. The Centre can accommodate fifty four guests. A number of the staff of the Tarff Trust transferred to the employment of the Abernethy Trust after the sale. A number of the activities and sites for activities were retained by the Abernethy Trust.
- (4) On Monday 24 July 2006 Laura McDairmant attended Barcaple to take part in a residential summer camp for children aged between 11 and 17 years. The camp was scheduled to run until 29 July 2006. Laura had attended similar camps at Barcaple in previous years. In July of 2006, she attended along with her twin sister, Rosie, and a number of friends.
- (5) A booking form and a pre-camp questionnaire were completed by Laura's mother and father, Sheila McDairmant and Brian McDairmant. In the forms agreement was given authorising the staff to act for the child according to their best judgement in any emergency situation requiring medical attention and to act in place of the parents in an accident or other situation demanding an immediate decision.

2. Events on 25th July prior to the accident

- (6) On the 25th July 2006 Laura was one of a group of young people participating in activities. In the afternoon the group went with instructors to the Grey Mare's Tail Burn, Galloway Forest Park to participate in an activity referred to as gorge jumping. This activity formed part of the programme offered at Barcaple and consisted of jumping from height into a pool of water.

- (7) As at 25th July 2005 Barcaple made use of two pools of water on the Grey Mare's Tail Burn for gorge jumping. The pools were accessed from a car park and pathways. From that point of access, the group went first to the pool further down stream. I will refer to that pool as the first pool. The group then went to another pool further upstream. I will refer to that pool as the second pool.
- (8) The first pool has over hanging sides and is in the form of a large pothole. There are two sites at different heights from which participants can jump. There are no obstacles to entry of the water from either of these points. The highest jumping off point is approximately 20 feet above the surface of the water. Laura had participated in gorge jumping at the first pool at a summer camp in 2005.
- (9) The second pool has formed at the base of the Grey Mare's Tail waterfall. At the edge of the pool there are ledges of rock, which protrude from the water level of the pool. There was one jumping point available for participants on a small clearing amongst vegetation. It is directly above a section of the protruding ledge of rock. This jumping point is 9.5 metres above the water level of the pool and is reached by walking down a grassy incline. The clearing there can only accommodate two people.
- (10) On the 25th July 2006 after lunchtime, the group arrived at the first pool for the start of the gorge jumping session. The group were wearing buoyancy aids in the style of a vest, which fitted over the shoulders and was secured by fasteners. They were given instruction on how to make jumps into water. They were told to cross their arms over their chest, take a confident step out from the edge towards the centre of the pool and to keep their legs and feet together on the descent. An instructor, Richard Farrell, demonstrated a jump.
- (11) The instructors Richard Farrell and Gareth Alcorn told the group that the jumps would be assessed by them to see whether or not a participant qualified to jump at the second pool. The instructors were looking for an ability to follow instructions, confidence and good body control in the air and on entry to the water. Laura made a number of satisfactory jumps and was assessed as having qualified to jump at the second pool.
- (12) The use of a qualifying jump to assess the ability of a young person to complete the jump at the second pool was misconceived. The pools differ in

nature and present different challenges. At the first pool the jump is from a lower point above the water and there are no obstacles to a clear entry into the water. At the second pool the jump is from a much higher point and a ledge of rocks have to be cleared to land in the clear, deep water.

- (13) The group moved upstream to the second pool. The group gathered around the side of the pool. The rocks partially submerged in the pool beneath the jumping point were visible and were pointed out by an instructor.
- (14) Richard Farrell repeated the instructions about how to make a jump. The group were told that they would have to jump off to the right from the jumping point in the direction that would be pointed out to them by the instructor. Richard Farrell told them that if they did not step out far enough he would give them a push.
- (15) Laura said to a friend that she would go to the top and see if she still wanted to make the jump. She appeared to be a little less confident than she had been at the first pool.
- (16) The group climbed up to an assembly area above the jumping point. Richard Farrell then demonstrated a jump. He went to the jumping point. He took a large step out heading to the right from the clearing and in the direction of the centre of the pool. This took him away from the ledge of rocks and into the clear water.
- (17) At the jumping point, the view of the pool below was restricted by trees and plants. The rock ledge below was not in full view. There is not enough room on that clearing to take a run up to the jump.
- (18) Richard Farrell then went back up to supervise. The group were well supervised at the assembly point at the top of the rocks. Gareth Alcorn positioned himself in the pool to assist with those landing in the water.
- (19) Richard Farrell then called on the participants to come forward one by one to make the jump. At the jumping point he asked if the person was still happy to do the jump. He then showed them where to place their feet and the direction in which to jump. He pointed out the position of the protruding rocks.
- (20) Richard Farrell was not secured by any method. Once a participant committed to a jump and stepped or jumped into the air, he could not control their direction or speed to ensure that they landed clear of the rocks. He had told the children that he would be able to give them a push if they were not jumping in

the right direction. He did not intend to do this and had only told the children this to give them some reassurance.

- (21) Laura went forward to jump at about 3pm in the afternoon. Approximately five or six people had jumped before her. She left the assembly point and walked down and joined Richard Farrell at the clearing.
- (22) Richard Farrell asked Laura if she was happy to jump and she stated that she was. He had no concerns about her confidence at that time. He pointed out the direction she should take when jumping. He then told her that she could make the jump when she was happy to do so.
- (23) Laura moved forward to the jumping point. She stepped back on one foot and then stepped forward over the edge of the rock face. She went to the right in the direction pointed out to her by Richard Farrell. She had committed to the jump and she was out over the edge. She then turned her body to the left and twisted, possibly in an attempt to bring herself back on to the clearing. The momentum of her forward movement prevented her from regaining the clearing. She fell to the left in the direction of the rocks below.
- (24) Richard Farrell reached out for her and tried to grab hold of her buoyancy aid. He did not get a hold of her. He was unable to assist her. Laura twisted further as she fell and the right side of her body was facing downwards. She fell a distance of 9.5 metres.
- (25) Laura landed at the bottom of the rock face on the protruding ledge of rocks. She landed on her side with her face downwards. Her lower jaw and throat took the main force of the impact.

3. Events on the 25th of July after the accident

- (26) Laura suffered numerous injuries to her neck, throat and jaw upon impact with the rocks. She also suffered a fracture to her right femur. There was a large open wound underneath her jaw.
- (27) Gareth Alcorn swam over to her and was at her side within seconds. He saw her injuries. He spoke to her but she did not respond. He was joined by Laura Denham, a trainee instructor.
- (28) Richard Farrell ran down from the jumping point and got the mobile telephone from the emergency kit. He was aware that there was no reception in that

immediate vicinity. He ran to the van, which was parked nearby and drove about half a kilometre to a point where reception was received.

- (29) Richard Farrell called the emergency services at 3:08pm. He requested the assistance of an ambulance, a mountain rescue team and an air ambulance. The operator advised him that she could not authorise an air ambulance. The reception then cut out and Richard Farrell immediately called back and gave further details.
- (30) At 3:15pm Police Officers Neill and McCormack were instructed to attend at the scene. The police control centre contacted the Scottish Ambulance control centre at 3:15pm to check that an ambulance had been ordered. At 3:26 pm paramedics in an ambulance were instructed to attend at the scene. A mountain rescue team in the area was alerted at 3:18pm.
- (31) Gareth Alcorn and Laura Denham assisted Laura and stayed by her side. Laura did not speak or communicate with them. She opened her eyes and made some noises. She made some movements of her arms and tried to touch her face. She did not appear to be fully conscious.
- (32) Gareth Alcorn put his leg underneath Laura's head to support her. This allowed him to tilt her head to assist her breathing and to prevent blood from collecting in her throat. Laura appeared to be taking air in through the wound at her jaw and for that reason it was decided not to cover the wound.
- (33) Police Officers Neill and McCormack arrived at the pool at 3:26pm. They had to wade through water and walk behind the waterfall to reach Laura. The officers did not administer first aid. They considered that Gareth Alcorn and Laura Denham were more qualified to do so.
- (34) The paramedics, Dennis McGinn and a colleague arrived at 3:41pm. The location of the track down to the Grey Mare's Tail from the road had been signalled to them by police officers and they were not delayed at all.
- (35) The paramedics took the same route as the police officers had taken to reach Laura. On examination they noted that Laura was very agitated. She appeared to be unconscious but was flailing her arms about. A nasal airway was inserted to assist with her breathing and gauze dressings were applied to her wounds
- (36) Laura was able to maintain an airway and the paramedics kept the airway clear by a suction apparatus. The open wound to her jaw was not dressed as the

paramedics were of the view that Laura may have been taking in air through that wound.

- (37) Other police officers attended at the scene. A mountain rescue team was training in the area and they also attended. There was discussion amongst those in attendance from the emergency services as to how Laura could be removed safely from the rocks and transported to hospital. It was decided that the only way to remove her to hospital was by air ambulance.
- (38) An air ambulance was requested at 3:31pm and attended at around 4:20pm. The helicopter hovered above the pool. A winch man and stretcher were lowered down. Laura was placed on the stretcher and lifted into the helicopter at 4:43pm. The paramedics had remained with Laura from their arrival until she was lifted into the helicopter.
- (39) In the air ambulance Laura was attended by paramedics and given treatment. The helicopter flew to the Dumfries and Galloway Royal Infirmary. In the course of the journey, Laura suffered a cardiac arrest and resuscitation was carried out.

4. Admission to hospital and medical treatment

- (40) Laura was admitted to the Accident and Emergency Department of the Dumfries and Galloway Royal Infirmary at 4:54pm. She was unconscious, had no heart beat and was not breathing. A heart beat was restored following resuscitation. She remained deeply unconscious. She had a score of 3 on the Glasgow Coma Scale.
- (41) On examination, Laura was found to have suffered a fracture to the lower jaw, bruising on the front of the neck and a fracture to her right femur. She also had surface injuries scattered over the rest of her body. A scan of her brain demonstrated diffuse cerebral oedema. She had suffered fractures to the floor of both orbits, a fracture of the maxilla, a right pneumothorax and a fracture to the central part of the pelvis.
- (42) The wound on her neck was sutured and the bleeding was controlled. She was then admitted to the intensive care unit. She was examined by a number of clinicians. She developed cerebral coning consistent with hypoxic brain damage.

- (43) The consultants at the hospital in Dumfries consulted with a neurosurgeon at the Western General Hospital in Edinburgh. The view was reached that her prognosis was abysmal and that no intervention was appropriate.
- (44) At 02:30am on the 26th July 2006 Dr Rutherford, consultant anaesthetist noted in her medical records that resuscitation would be futile.
- (45) On the 26th of July 2006 brain stem tests were performed. The doctors were satisfied that Laura was suffering from irremediable brain damage and that there was an absence of brain stem function. At 15:05 hours on that date brain stem death was confirmed.
- (46) The nature of the injuries, which Laura sustained were such that there was very little that could have been done to save her life.
- (47) The hypoxic damage to her brain was caused by a number of factors. The bleeding into the tissues around her lower jaw and throat affected her breathing. The blood loss and the difficulties with breathing brought about the cardiac arrest, which in turn produced a lack of oxygen for the brain and hypoxic brain damage occurred. The traumatic injuries sustained in the fall may also have caused Laura to lose consciousness and that would have compounded the difficulties in supplying oxygen to her brain.

5. Post Mortem examination

- (48) On 28th July 2006 at Dumfries and Galloway Royal Infirmary a post mortem examination was conducted by Dr John Clarke and Dr Robert Ainsworth. They concluded that Laura McDairmant had died as a result of hypoxic brain damage due to injuries to her face and neck due to a fall from height

6. Examination of the scene by the police

- (49) Police Constable John Baillie is qualified and experienced in the investigation of collisions. He surveyed the area of the second pool and used surveying equipment to make measurements. The distance from the point where Laura jumped is 9.5 metres vertically above the rocks where she landed. The rocks where she landed continue out into the pool for a distance of 1.5 metres from a point directly below the jumping point.

- (50) Officer Baillie used these measurements to calculate that a person who performed a jump would require to travel forward at a speed of 2.4 miles per hour in order to clear the rocks below.

7. The suitability of the second pool for jumping

- (51) The second pool was not a safe site for the activity of gorge jumping. To clear the rocks below, a participant would require sufficient momentum to travel more than 1.5 metres out from the rock face. There was a significant risk that a participant would fail to gain sufficient forward momentum to carry them beyond the rock ledge.
- (52) The risk of a participant failing to clear the rock ledge below could not be managed or reduced. Once a participant had committed to making a jump, the instructor present could not manage the direction in which they travelled or prevent the participant from falling in the direction of the rock ledge.
- (53) The Abernethy Trust has acknowledged its responsibility for the failure to prevent the use of an unsafe site. On the 23rd October 2008, the Abernethy Trust tendered a plea of guilty to an indictment containing a charge under sections 3 and 33 of the Health and Safety at Work Act 1974 relating to the use of the site. The Abernethy Trust was fined the sum of £16,000.

8. Introduction of gorge jumping at the second pool at Barcaple

- (54) In the period from January of 2001 until December of 2003, Andy Giles was the Chief Instructor at Barcaple. In 2002, he introduced an activity called “gorge walking” at the Grey Mare’s Tail Burn. As part of that activity he introduced jumps into the first and second pools. At the second pool the jumping off point used was the same clearing from which Laura fell.
- (55) The activities of gorge walking and gorge jumping are not governed by a National Body. There is at present no specific qualification, which can be gained for these activities.
- (56) The guidance issued by the Health and Safety Executive on the operation of the Adventure Activities Licensing Regulations 2004, Crown Production 39 refers, recommends for gorge walking that the appropriate level of qualification is a Mountain Instructor Certificate, British Mountain Guide or Mountain Instructor Award. Gorge walking is interpreted in the guidance as

coming under the definition of climbing when safety requires the use of equipment or the skills and technique of a rock or ice climber.

- (57) The nature of the site for jumping at the second pool raises safety requirements at a level equivalent to those referred to in the guidance.
- (58) The Abernethy Trust Safety Standards in place in 2002 did not require Mr Giles to seek the approval or authorisation of any senior member of the Abernethy Trust to introduce a new activity at a new site.
- (59) Mr Giles had gained a number of qualifications from National Governing Bodies in water sports and rock climbing. Mr Giles did not hold the Mountain Instructor Certificate, British Mountain Guide or Mountain Instructor Award. Mr Giles did not seek the approval or authorisation of a senior member of the Trust for the activity of gorge jumping at the first and second pools.
- (60) Mr Giles had not built up sufficient experience in the field of outdoor activities by 2002 to make a fully informed assessment of the risks presented at the second pool. He failed to appreciate the risk posed by the ledge of rocks directly below the jumping point. Mr Giles made an error of judgement in assessing the jumping off point at the second pool as a suitable site for jumping into water.
- (61) Mr Giles was under the impression that he had discussed this decision with Steve Spalding, the technical adviser for the Abernethy Trust, and had gained his approval.
- (62) Steve Spalding was not asked to provide technical advice on the suitability of the pools for gorge jumping prior to the introduction of the activity. He did not give his approval for the use of the second pool for gorge jumping. Had Steve Spalding inspected the second pool he would have not given his approval for the use of the site for gorge jumping.
- (63) The Abernethy Trust Safety Standards stated that a site-specific risk assessment was to be created for a new activity. Mr Giles did not produce a written site-specific risk assessment for the activity.
- (64) A written risk assessment was produced, Crown Production 14 refers. It is not known who wrote this risk assessment or when it was written. The document did not identify the location where the activity was conducted. It did not identify that two pools were being used. No reference was made to the use of the first pool as a training jump for the jump at the second pool. The document

does not fulfil the purpose of a site-specific risk assessment as it does not identify the site.

- (65) The risk assessment failed to identify the risk posed by the rock ledge at the foot of the rock face at the second pool. The risk of striking a rock on descent was categorised as having a low probability and a medium to high severity. This does not reflect the true nature of the risk presented by the rock ledge at the second pool.
- (66) The Operations Director at that time, David Pratt, was not aware that the activity of gorge jumping had been introduced and was taking place at the pools on the Grey Mare's Tail Burn.

9. The continued use of the second pool for gorge jumping

- (67) The activity of gorge jumping at both pools continued at Barcaple until 25th July 2006. The Chief Instructor in post held responsibility for the conduct of outdoor activities, which included gorge jumping.
- (68) In the period from the introduction of the activity to the accident, a number of persons held the post of Chief Instructor. Andy Giles was in the post from January 2001 until he left Barcaple in November 2003. He was replaced as Chief Instructor by Andrew Mills, who was shortly thereafter replaced by Colin Slogrove. Colin Slogrove left in March 2006.
- (69) After Colin Slogrove left in March of 2006, David Pratt took over the responsibilities of the post of Chief Instructor. Mr Pratt was not sufficiently well qualified or experienced to fulfil the role of Chief Instructor.
- (70) Mr Pratt was not aware of gorge jumping being conducted as an activity at Barcaple. He was not aware of the use of the site at Grey Mare's Tail Burn for any activities and he had not attended a gorge jumping session or visited the site.

10. Concerns expressed about the use of the second pool

- (71) In summer of 2005, Helen Bollister was working as an instructor at Barcaple. She attended a gorge jumping session at the Grey Mare's Tail pools as an assistant to Colin Slogrove who was leading the session. Colin Slogrove was the chief instructor at that time.

- (72) Helen Bollister had concerns about the jumping off point at the second pool. She considered that the step down to the jumping off point was awkward and that participants would have to step out as they jumped in order to clear the rocks at the foot of the jump.
- (73) At the end of the session, Helen Bollister climbed to the jumping off point at the second pool and dropped a stone off to test her concerns about the rocks below. She heard the stone hit the rocks. This confirmed her concerns and she formed the view that it would difficult to ensure that participants jumped out far enough to clear the rocks.
- (74) Helen Bollister raised her concerns with Colin Slogrove. She advised him that she was not totally convinced that there was a method to ensure that participants stepped out far enough to clear the rocks. She does not recollect his response in detail. She thought that he had agreed with her to some extent but did not seem overly concerned. She did not report her concerns to anyone else at Barcaple.
- (75) In summer of 2005 David Moss was working as an instructor at Barcaple. He attended a gorge jumping session at the second pool. He was not instructing at that session. He watched while the instructors and some of the children in the group jumped from the jumping off point at the second pool.
- (76) David Moss formed the view that there was a risk that a person jumping might not clear the rocks at the bottom. He considered that by the law of averages, it was only a matter of time until someone failed to clear the rocks.
- (77) After that session, David Moss raised his concerns with Colin Slogrove, the Chief Instructor. David Moss thought that his concerns were taken seriously.
- (78) The use of the second pool was discussed at a later meeting of the instructors and David Moss again made very clear his concerns about the second pool. The other instructors present included Colin Slogrove and Richard Farrell. The other instructors did not agree with David Moss and the general view was that the jump was safe if properly managed. It was agreed that David Moss would not be asked to take sessions at the second pool.
- (79) One evening in the summer of 2004 a number of instructors and friends were at the second pool in their free time and were making jumps from the jumping off point at the second pool. In their group was a man called Warren Jay.

- (80) Warren Jay slipped on take off when making a jump and was falling in the direction of the rocks. He had to move his body in mid-air to ensure that he cleared the rocks at the bottom. He was advised by others that he had only just cleared the rocks.
- (81) Warren Jay is the brother-in-law of Colin Slogrove. He advised Mr Slogrove about this incident.
- (82) Colin Slogrove was aware of the concerns of Helen Bollister and David Moss. He was aware of the incident involving Warren Jay. He did not advise senior staff of the Trust of these matters. There was no procedure in place to ensure that a written record was kept when safety concerns were raised. There was no system in place of reporting safety concerns to the Operations Director.
- (83) Mr Pratt, the Operations Director, was not aware of the concerns expressed or of the incident involving Warren Jay.
- (84) In November of 2005, Colin Slogrove wrote an e-mail to Stephen Spalding asking him to visit Barcaple and discuss, amongst other matters, the site in use for gorge jumping. This was agreed to by Mr Spalding but the proposed visit did not take place. Colin Slogrove left Barcaple in March of 2006.

11. The management of Barcaple Centre and the safety procedures and policies in place at 25th July 2006

- (85) In July 2006 Abernethy Trust had in place safety standards, which permitted a Chief Instructor to introduce the activity of gorge jumping without reference to the Technical Adviser or other senior member of staff.
- (86) David Pratt was appointed as the Operations Director when the Abernethy Trust took over Barcaple in January 2001. He was still in post at the time of the accident. Mr Pratt had overall responsibility for the management of the centre and all the activities undertaken.
- (87) Mr Pratt held a qualification as a mountain bike leader. He did not hold any other qualifications related to outdoor activities. He was not experienced in the adventure activities sector. He had experience of management in other areas.
- (88) The Chief Instructor and the team of instructors were responsible for the supervision and management of the outdoor activities at Barcaple. Mr Pratt was reliant on the instruction staff for management of the outdoor activities.

- (89) At the time of the accident on 25th July 2006, Mr Pratt was the acting Chief Instructor. He took on that role when Colin Slogrove left Barcaple. Mr Pratt did not have the requisite training or knowledge to assess the risks posed by gorge jumping at the second pool.
- (90) Mr Pratt had not attended all the sites at which activities were being undertaken by clients. He was not aware of all the activities being offered. He was not aware that gorge jumping was being undertaken by groups of young clients at the pools at the Grey Mare's Tail Burn. Mr Pratt did not take steps to keep himself advised of all the outdoor activities being conducted at the centre.
- (91) Mr Pratt was not advised that David Moss and Helen Bollister had concerns about the use of the second pool. He was not advised of the incident involving Warren Jay.
- (92) The communication between Mr Pratt and the instructing team was not satisfactory.
- (93) There was a system in place for the annual review of risk assessment documents for all activities. The review was the responsibility of the Chief Instructor.
- (94) Gorge jumping was part of the activities at the centre from 2002 until 2006. The risk assessment for gorge jumping in use at 25th July 2006 was inadequate and did not serve the purpose of a site-specific risk assessment. The risk assessment was either not reviewed or any review of it was not satisfactory. The system for the review of risk assessments did not operate adequately.
- (95) There was no system in place to ensure that safety concerns were raised by the Chief Instructor with his Operations Director or other senior member of the Trust. There was no system in place to record any safety concerns raised and any discussion about them by members of staff.

12. The inspection of Barcaple by the regulatory bodies

- (96) The Barcaple Centre is subject to the licensing scheme set up under the Adventure Centres (Young Persons Safety) Act 1995 (the 1995 Act). Between 2001 and 2006, Barcaple was inspected on an annual basis by Robert Telfer, an inspector from the Adventure Activities Licensing Authority (A.A.L.A.). A licence was granted following upon each of these inspections. The inspections

consisted of a visit on a single day and an inspection of some of the activities on offer that day.

- (97) On 25th July 2006 Barcaple held a licence from A.A.L.A. to provide facilities for adventure activities. The activity of gorge jumping is not a licensable activity in terms of the 1995 Act.
- (98) The inspector for A.A.L.A, Robert Telfer did not know that gorge jumping at the pools was being conducted as an activity for the clients of Barcaple. Mr Telfer had not visited the site at the Grey Mare's Tail Burn prior to the accident.
- (99) Barcaple is subject to the provisions of the Health and Safety at Work Act 1974 (the 1974 Act) and regulations made under that act. It was subject to the inspection scheme in terms of that legislation and the enforcing authority at the time of the incident was Dumfries and Galloway Council. The inspection scheme was administered by the Environmental Health Service Officers (EHO's) employed by the Council. The site at Grey Mare's Tail Burn had not been inspected by the Council prior to the accident.
- (100) The Environmental Health Services of the Council did not know what type of adventure activities were being provided at Barcaple and did not know that gorge jumping was being conducted as an activity.
- (101) The Council operated a policy of not conducting planned inspections of a provider of adventure activities if that provider was inspected by the A.A.L.A.
- (102) The Environmental Health Services of the Council did not inspect any of the activities taking place out with the centre at remote sites. Their inspections were confined to the premises and grounds at Barcaple.
- (103) The officers and management of the Environmental Health Services had formed the erroneous view that they were not entitled under the health and safety legislation to inspect sites outside the boundaries of Dumfries and Galloway Council. The site at the Grey Mare's Tail Burn is out with the boundaries of the Council.
- (104) The Environmental Health Services of the Council did not make contact with the A.A.L.A. to liaise on the issue of the inspection of sites providing adventure activities within their jurisdiction. The A.A.L.A sent copies of the licenses issued to Barcaple to the Council but did not enclose the reports of their inspections of the facility.

13. Changes by Abernethy Trust to management and systems after 25th July 2006

- (105) The activity of gorge jumping at the Grey Mare's Tail Burn was immediately discontinued by the Abernethy Trust.
- (106) A review of all safety management procedures and risk assessments was conducted by the Abernethy Trust. The Director of Training, Barry Edmondson visited and approved all of the sites used by the Abernethy Trust at all of its centres. Mr Edmondson has undertaken a review of all safety management procedures and risk assessments.
- (107) The Abernethy Trust safety standards now require that the introduction of a new site or a new activity has to be approved by the Director of Training. Any new Centre acquired by the Trust would be subject to these policies
- (108) The Abernethy Trust has introduced additional training for its staff. It has introduced a system of warning cards to ensure that safety concerns are recorded and brought to the attention of senior staff.
- (109) An independent check is now required when any new activity is introduced. A Chief Instructor is required to discuss the introduction of any new activity with one of the technical advisors for the Trust. Should the activity be one for which the technical advisor is specified as the Chief Instructor, the matter requires to be referred to the Director of Training.
- (110) The Trust has revised their risk assessments to ensure that all are fully site specific, and contain more and better information about the management of risk. All risk assessments are required to be site specific.
- (111) The Trust now keeps a list of all approved venues and sites.
- (112) Instructors now receive additional training on the importance of reporting any safety issues arising in the course of their work or leisure. A card warning system has been instituted to ensure that all safety issues reported by staff are recorded and brought to the notice of senior staff.
- (113) The Trust now regards the employment of an unqualified Operations Director to fill the role of Chief Instructor as being unacceptable.
- (114) These changes have created a satisfactory system of safety management within the Abernethy Trust.

PART III: DETERMINATION AS TO THE CIRCUMSTANCES OF THE DEATH

The Sheriff having considered all the evidence adduced FINDS AND DETERMINES in terms of Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:

1. In terms of Section 6(1)(a) that;

Laura McDairmant, born 16 April 1991, died at the Dumfries and Galloway Royal Infirmary, Dumfries at 15:05 hours on 26 July 2006 following an accident at approximately 15:12 hours on 25 July 2006 at a pool on the Grey Mare's Tail Burn, Galloway Forest Park;

2. In terms of Section 6(1)(b) that ;

- (i) The cause of her death was :-

a: Hypoxic Brain damage

due to

b: Injuries to her face and neck

due to

c: Fall from height

- (ii) The cause of the accident was the use of the pool at the Grey Mare's Tail Burn, Galloway Forest Park by the Barcaple Centre for the activity of jumping from height into water. The site was unsafe and should not have been used for the activity. There was a rock ledge protruding from the pool underneath the jumping off point. There was a danger that a participant would fall onto that rock ledge. Laura McDairmant jumped from a height of approximately 9.5 metres above the surface of a pool of water there. She landed on the protruding ledge of rocks and sustained the injuries, which caused her death.

3. In terms of Section 6(1)(c) that the reasonable precautions whereby the death and the accident resulting in death may have been avoided are as follows:
- 1) The site of the second pool at the Grey Mare's Tail Burn should have been inspected and approved before its use, by a senior member of staff of the Abernethy Trust, holding a qualification to the level of, or equivalent to, the Mountain Instructor Certificate, British Mountain Guide or Mountain Instructor level. Had the site been subject to that level of inspection, it is highly probable that the site would not have been used for the activity.
 - 2) The activity of gorge jumping should not have been introduced at the Barcaple Centre on the approval of a single member of staff. Had another senior member of staff been consulted about gorge jumping at that pool it is possible that the risk of falling onto the ledge of rocks would have been appreciated and the activity would not have been introduced.
 - 3) The activity of gorge jumping should not have been introduced at the Barcaple Centre without the production of a written risk assessment containing full details of the location of the site and a proper assessment of the risks of injury presented by the protruding ledge of rocks. Had a written risk assessment in proper form been produced it is possible that the risk of falling onto the ledge of rocks would have been appreciated and the activity would not have been introduced.
 - 4) The concerns raised about the safety of gorge jumping at the second pool prior to the accident should have been acted upon and an inspection of the site undertaken by a senior and suitably qualified member of staff. Had such an inspection been instructed it is highly probable that the activity would have been stopped prior to the accident.
 - 5) The written risk assessment for gorge jumping at the Barcaple Centre should have been properly reviewed prior to the accident. Had the document been so reviewed, it would have been apparent that the

document was not site-specific and required to be reconsidered. Such reconsideration might have involved a further assessment of the risk at the site and might have led to the risk of falling onto the ledge of rocks being appreciated and the suspension of the activity prior to the accident.

4. In terms of Section 6(1)(d) the following defects in systems of working contributed to her death;

- 1) The Abernethy Trust did not have in place an adequate safety policy on the introduction of new activities at their activity centres. The safety procedures allowed for the introduction of the activity of gorge jumping on the approval of a single member of staff at the level of Chief Instructor without the approval of a more senior and more highly qualified member of staff.
- 2) The Abernethy Trust was not aware of all the activities provided or all of the sites used at their activity centres. The Trust were not aware that young persons attending courses at the Barcaple Centre were engaging in gorge jumping into a pool of water from a height of 9.5 metres where there was a risk of striking a ledge of rocks at the foot of the descent.
- 3) The management of safety measures for outdoor activities at Barcaple as at 25th July of 2006 was inadequate in the following respects;
 - a) The operations director, Mr Pratt was not well enough qualified in the area of outdoor activities to manage to an acceptable standard, the outdoor activities engaged in by young persons at the centre
 - b) Mr Pratt was not qualified to hold the position of Acting Chief Instructor, which position he held from March 2006 until the date of the accident.
 - c) There was poor communication between Mr Pratt and the team of instructors on the issue of the management and operation of the outdoor activities at the centre. Mr Pratt was unaware that the young persons were participating in the activity of jumping from

height into the pools of water at the Grey Mare's Tail Burn. Mr Pratt was unaware that concerns had been raised by members of staff about the suitability of the second pool for the activity of jumping

- d) The system for producing written risk assessments and ensuring a thorough annual review of the documents was not adequately supervised. Gorge jumping was introduced in 2002 at the centre. A written risk assessment was not produced at that time. The written risk assessment in place for gorge jumping at the time of the accident in July 2006 was not in the correct form and did not identify the location of the site or describe the level of risk at the second pool. It did not serve the purpose for which it was intended.
- e) There was no system in place at the centre to ensure that a written record was kept of any safety concerns raised. There was no system to instruct staff what action to take when a safety concern was raised. There was no system in place to ensure that the Operations Director was informed if any safety concerns were raised.

5. That in terms of section 6(1) (e) of the Act that the following facts are relevant to the circumstances of her death:-

- 1) The activity of gorge jumping provided by Barcaple was not subject to inspection under the licensing scheme administered by the A.A.L.A. The activity did not fall within the definition of an adventure activity under the Adventure Activities Licensing Regulations 1996. It is a matter of concern that an activity, which had a significant risk of serious injury or death, was not covered by the licensing scheme.
- 2) The responsibility for the inspection of the adventure activities provided at the Barcaple Centre was divided between Dumfries and Galloway Council and the A.A.L.A.. There was very little contact between Dumfries and Galloway Council and the

A.A.L.A. The demarcation of responsibilities between the two bodies had not been discussed.

- 3) The Council and the A.A.L.A were not aware that gorge jumping was going on at the second pool. It is a shortcoming in the present regulatory scheme that there was no system in place to ensure that one or other of the authorities were advised that young persons were engaging in the activity. It would only have been by chance that an A.A.L.A inspector might have come across the activity during an annual inspection.
- 4) The activity of gorge jumping at Barcaple had not been subject to an inspection by the local authority, Dumfries and Galloway Council prior to the accident. The Council operated a policy that providers of adventure activities were not subject to planned inspections if the provider was inspected by A.A.L.A. In terms of this policy, the Council did not conduct any inspections of the adventure activities at Barcaple prior to the accident. This policy was put in place in response to guidance given to Dumfries and Galloway by the Health and Safety Executive under Local Authority Circular 47/15. It is of considerable concern that this policy led to gorge jumping at Barcaple being removed from the scheme of systematic inspection.

PART IV: NOTE ON EVIDENCE

1. Introduction

- (1) In view of the volume of evidence heard in the course of the Inquiry, I have not recorded the evidence in detail, except where I considered it was of assistance. I have summarised my findings under separate sections of the evidence.

2. Evidence of the young persons in the group

- (2) I heard evidence from a number of the young people in the group that day. I was satisfied that all these witnesses tried to tell the truth to the best of their recollection. I concluded from their evidence that gorge jumping was a very popular activity and that they enjoyed the challenges and the excitement the session offered. The witnesses spoke of having respect for the instructors who were with them that day and to placing their trust in the abilities of the instructors to protect and keep them safe.
- (3) The session was well supervised and the instructors gave adequate instructions on the technique to use when jumping. I am satisfied that neither Laura nor anyone else in the group came under any pressure to jump at the second pool.

3. Evidence of the instructors and trainees present

- (4) I also heard evidence from the instructors and trainees who were in attendance. I was satisfied that in relation to the events at the second pool on the 25th of July, they did seek to tell the truth and assist the Inquiry as much as they could.
- (5) The instructors and trainees supervised the sessions appropriately that day. The instructors and trainees all reacted appropriately to the accident and gave Laura as much assistance as they could. The emergency services were alerted as promptly as was possible given the remote location.

4. Evidence of the police and paramedics in attendance

- (6) I am satisfied that the witnesses were able to provide me with a good account of the medical assistance given to Laura and the arrangements made for her removal to hospital. The assistance given to Laura was of an acceptable

standard given the location where she fell and the difficulties in access. I am satisfied that nothing further could have been done to improve upon the medical assistance rendered.

5. Evidence of the medical treatment

- (7) I was satisfied from the evidence of Dr Jefferson and the information in the medical records, that Laura received the appropriate medical treatment during the time she was at the Dumfries and Galloway Royal Infirmary. A number of doctors from different disciplines contributed to her care. Advice was sought from a specialist neurosurgeon at an early stage.
- (8) I am satisfied that the nature of her injuries were such that there was little prospect of her surviving. The damage to her brain was caused by a number of factors, all of which interacted. There was no treatment for the damage to her brain and she could not have survived.

6. Evidence of the Post Mortem examination

- (9) The evidence of the Post Mortem was in the form of an affidavit by Dr John Clark, Crown Production 6 refers. The examination confirmed the nature and extent of the injuries.

7. Evidence of the examination of the scene by the police

- (10) Police Sergeant John Baillie conducted an examination of the second pool. He used an electronic theodolite to take accurate measurements and then calculated the speed required to be achieved to clear the rocks below. The officer produced a report, Crown Production 9 refers. I was satisfied with the methods used and that I relied upon the terms of this report.

8. Evidence on the suitability of the second pool for jumping

- (11) The Crown led evidence from experts in the field of outdoor activities and much of this was directed to the issue of the suitability of the second pool for gorge jumping. As the inquiry progressed it became apparent that the weight of the evidence favoured the conclusion that the site was unsafe and ultimately in their submissions all parties were agreed on that issue.

- (12) I have had little difficulty in reaching the conclusion that at the jumping point at the second pool there was a significant risk of a participant falling from height and landing on rocks below. I was also satisfied that this risk could not be adequately managed. The site was unsafe for the activity.
- (13) The Crown led evidence from Mr Franco Ferrero who has very considerable experience in the field of outdoor activities. He prepared a report, Crown Production 11 refers. He has a breadth of experience in water sports and rock climbing and has been involved in the organisation of activity courses and has trained instructors for such courses. He holds a number of qualifications in outdoor pursuits. He gave evidence in a clear and authoritative manner. I was satisfied that he had the requisite knowledge and experience to provide the Inquiry with an expert opinion.
- (14) Mr Ferrero examined the second pool and the jumping point and produced a report on his findings. He concluded that the site was not suitable for the activity with a client group of young people. He considered that there was “*too much objective danger*” at the site as the consequence of failing to clear the rocks below is almost certain death. He was of the view that if a participant slipped, tripped or went weak at the knees or changed their mind mid-stride, they would almost certainly die.
- (15) Mr Ferrero described the probability of someone failing to clear the rocks as “*incalculable*”. He considered that although it can be relatively straight forward for a fit person to make a jump of five feet from a standing start, the distance required to clear the ledge of rocks below, the issue can become a person’s psychological ability to make such a jump.
- (16) The Crown led evidence from William McKay, a consultant in relation to adventure activities. He prepared a report, Crown Production 44 refers. He has considerable experience of the outdoors and holds a number of relevant qualifications. He had many years of experience in the Army Physical Training Corps. He gave his evidence in a clear and compelling manner. I was satisfied that he had the requisite knowledge and experience to provide the Inquiry with an expert opinion.
- (17) Mr McKay examined the second pool and the jumping point and produced a report on his findings. He concluded that the jumping point at the second pool required “*total focus and commitment ...from participants and there is no*

room for error as the consequences ..are grave". He was of the view that this type of jump should only be attempted by an adult who had accepted responsibility for the risk.

- (18) Both experts were agreed that the use of the first pool as a "qualifying jump" was ill-conceived. The pools present quite different challenges and the jump at the second pool is far higher and more daunting than the first pool.
- (19) Both experts were agreed that it would not be possible to put in place an adequate system for securing an instructor to allow that instructor to take hold of a participant and prevent them from falling in the direction of the rocks.
- (20) Robert Telfer, an inspector for A.A.L.A gave evidence. He had been asked to prepare a report by the police at an early stage. He produced a report on his findings in August 2006, Crown Production 10 refers. Mr Telfer is experienced in the field of outdoor activities and has been employed as an inspector by A.A.L.A since 1997.
- (21) In his report and in evidence, Mr Telfer expressed the view that jumping from height is an activity, which is commonly undertaken by young people during adventure activity courses. He stated in evidence that a jump of the type at the second pool was not uncommon in the outdoor activity community. This evidence was in contrast to that given by the Mr Ferrero and Mr McKay.
- (22) When it was suggested to Mr Telfer in examination that his opinion was at variance with persons who may be viewed as experts, he qualified his opinion by stating that he only considered the site to be suitable if the manner in which the participant jumped could be managed. On being pressed on this issue to give examples of how this would be achieved, Mr Telfer conceded that this was not an area in which he felt able to give an expert opinion. He suggested that an instructor could be roped or secured in some fashion but conceded that he was not in a position to state how that could be achieved.
- (23) I have reached the view that the evidence of Mr Telfer does not amount to the expression of a view that the site at the second pool was suitable for jumping. His opinion on its suitability is based on the assumption that the manner in which a participant executes a jump can be managed. I have accepted the evidence of Mr Ferrero and Mr McKay that there is no satisfactory method for managing the way in which a participant jumps. I consider that they are better qualified than Mr Telfer to express opinions on this issue.

- (24) I also heard evidence from senior Environmental Health Officers, Derek Collins and Steve Dunn, on the issue of the suitability of the second pool for jumping. Both expressed the clear view that had they been called upon to inspect the second pool, they would have recognised the risk posed by the ledge of rocks and would have served a Prohibition Notice to prevent the activity from continuing. I accepted this evidence and was satisfied that they were both well-placed to provide an opinion on the issue given their experience.
- (25) Two senior members of the Abernethy Trust, Dr Philip Simpson and Barry Edmondson gave evidence of their inspection of the site after the accident. Both considered that they would not have allowed gorge jumping to take place at that location. I considered their evidence gave further support to the conclusion that the site was unsafe.

9. Evidence on the introduction of gorge jumping at the second pool

- (26) The evidence on this issue was not clear and witnesses appeared to have difficulty recalling detail given the passage of time.
- (27) Gorge walking or jumping are not governed by any National Governing Body (N.G.B.). In 2006 Abernethy Trust had in place a safety standards document Crown Production 13 refers, which provided that where there was no N.G.B to provide a measure of competence, the choice of a site was to be determined by a technical adviser and a site-specific risk assessment. The document categorised gorge walking as an activity in which the technical advisor would be a Chief Instructor “*working with an MIA*”. An MIA is reference to a person holding a Mountain Instructor Award. Steve Spalding, the technical advisor for the Abernethy Trust, holds that level of award. Mr Giles did not hold that level of award.
- (28) I accepted the evidence of Andy Giles that as the Chief Instructor he had introduced gorge walking as an activity in 2002 and that jumps into both the first and second pools were included. Mr Giles was very frank and stated that he now realises he did not have sufficient experience to make a judgement on the suitability of the second pool for gorge jumping. He now accepts that he made an error of judgement and that the site was unsafe.

- (29) Under the existing safety standards, Mr Giles was authorised to introduce this activity without reference to senior colleagues. The words “*working with an MIA*” had been interpreted by Mr Giles as covering the discussions he thought he had had with Steve Spalding.
- (30) He gave evidence that he had consulted by telephone with Stephen Spalding, the technical director, and been given the go ahead to make that decision. I did not accept the evidence of Mr Giles on this point and consider that he was mistaken rather than untruthful. I accepted the evidence of Mr Spalding that he was not consulted and his position was supported by his subsequent communications in November 2005 with Barcaple about proposed visits to the pools used for gorge jumping.
- (31) Mr Giles also gave evidence that he had visited the Grey Mare’s Tail Burn along with Stephen Spalding. He stated in evidence that Mr Spalding had said that the jumping point at the second pool was not safe and was not to be used. Mr Giles stated that he communicated this to other instructors and after that the second pool was not used for jumping.
- (32) Mr Spalding differs in his evidence on this issue. He was clear that he had not visited the site with Mr Giles and had issued no instructions about the second pool. Mr Spalding accepted that there had been a visit during which gorge walking had been discussed but gorge jumping at the pools had not been covered.
- (33) I accepted the evidence of Mr Spalding that he did not visit the second pool with Mr Giles and had not instructed that the second pool was not to be used for jumping. I formed the view that Mr Giles was incorrect in his recollection of events. I did not think that he was being untruthful. I concluded that his memory was poor on this issue given the passage of time.
- (34) Mr Spalding accepted that there had been a visit during which gorge walking had been discussed but gorge jumping at the pools had not been covered. I have concluded that Mr Giles is mistaken in his recollection of discussing gorge jumping with Mr Spalding. I have accepted the account of Mr Spalding on this matter.
- (35) In evidence, Mr Giles stated that he had not trained any other instructors to lead sessions in gorge jumping at the pools and that he had not “signed them off” as qualified to lead sessions. He stated that he understood that gorge

jumping was not a part of the programme at Barcaple after Mr Spalding had instructed that it was to stop.

- (36) The witness Richard Farrell gave evidence in direct contradiction to Mr Giles on these matters. It was his position that he had been trained by Mr Giles in how to make the jumps and had assisted him with school groups engaging in the activity. Mr Farrell stated that he had been “signed off” by Mr Giles to lead sessions. It was also his position that gorge jumping continued at Barcaple after Mr Giles left and up to the date of the accident.
- (37) I have found it hard to reconcile the evidence of Mr Giles and Mr Farrell. I have concluded that I cannot accept the position of Mr Giles that gorge jumping stopped at Barcaple prior to his departure in late 2003. It is clear that gorge jumping did continue at Barcaple. On the issue of the training of Mr Farrell, I have been unable to rely upon the evidence of either Mr Giles or Mr Farrell. I consider that the witnesses have an incomplete recollection of events and I am not in a position to reach a conclusion on who trained or signed off Mr Farrell.
- (38) On the issue of the introduction of gorge jumping at Barcaple, which is a central issue, I am satisfied that the activity was introduced by Andy Giles as Chief Instructor. He made an error of judgement and his decision was not reviewed or authorised by any other member of staff at the Abernethy Trust. I am satisfied that the activity of gorge jumping, including the use of the second pool, took place as a summer activity at Barcaple between its introduction in 2002 and the accident involving Laura in July 2006.

10. Evidence on the continued use of the second pool and the concerns expressed

- (39) The evidence on these issues was confused by the varying recollections of witnesses and by the fact that members of staff in post in the period were not available to be led in evidence. Further, there is an absence of any written records of discussions at meetings of the instruction team in the period from 2002 through to 2006.
- (40) I have accepted the evidence of Helen Bollister and David Moss and have concluded that there were concerns raised about the second pool prior to the accident involving Laura. I have also concluded that the incident involving

Warren Jay, whilst not during a supervised session, should have demonstrated the danger posed by the rock ledge in the second pool.

- (41) I did not accept the evidence of Richard Farrell that he was not aware of concerns raised by David Moss about the second pool. He was also of the view that the incident involving Warren Jay was not significant as Warren Jay was prone to acting recklessly and had not made the jump as he should have. I had the impression that Mr Farrell sought to minimise the importance of that incident.
- (42) I formed the view that Mr Farrell was uncomfortable and evasive in his evidence on the issue of the concerns raised about the second pool. I could not accept that he was giving me an accurate account although I did not consider he was lying. It was apparent that he has been deeply affected by the death of Laura. It was my impression that he may feel a sense of guilt and now think that he did not give sufficient attention to these warning signs. I reached the conclusion that for that or some other reason, he found it difficult to be candid on the matter.
- (43) Mr Colin Slogrove, the Chief Instructor who left that post in March 2006, did not give evidence. Mr Slogrove now resides in Australia and was unavailable to attend as a witness.
- (44) Mr Slogrove may have been able to provide useful information on why the decision was taken to continue the activity. He was the person to whom both Helen Bollister and David Moss spoke to regarding their concerns about the second pool. I also considered that the evidence led supported the conclusion that Mr Slogrove was aware of the incident when Warren Jay landed in the pool narrowly missing the rocks.
- (45) It would have been helpful for the Inquiry to hear evidence of why Mr Slogrove had asked Mr Spalding to come to Barcaple to discuss the site for gorge jumping. It would also have been of assistance to hear evidence about why the second pool continued to be used when Mr Spalding had not been able to inspect the site and discuss the activity.
- (46) In the absence of the written records and an account by Mr Slogrove, I consider that it is not possible to reach a concluded view of the precise circumstances in which gorge jumping stayed on the programme until 2006.

- (47) It would appear from the evidence that when successive Chief Instructors and instructors took up their posts, the activity was well-established and was being operated by an instruction team comprised of well-qualified and well-trained staff. It was a popular activity with clients, particularly in the teenagers. There may well have been an assumption by successive instructors and Chief Instructors that the activity had been assessed as being safe and this was not questioned. This view would have been given support by the lack of any accidents until the fatal accident involving Laura.
- (48) I am also satisfied that the system for reviewing risk assessments on an annual basis did not operate satisfactorily. The risk assessment for gorge jumping remained in an unsatisfactory form right up until the accident. The document was either not reviewed or any review was inadequate.

11. The management of Barcaple and the safety procedures and policies in place at 25th July 2006

- (49) On the evidence on these issues, I have reached the view that outdoor activities at the Barcaple Centre in the period from 2001 until the accident were not adequately managed. The Operations Director in post, Mr Pratt, was not qualified in outdoor activities and left outdoor activities under the control of the instructors. Mr Pratt did not keep himself fully informed of all the activities going on and did not make sufficient effort to find out.
- (50) There was an absence of any system to record any safety concerns raised. The system for the review of risk assessments was inadequate. The safety procedures in place in July 2006 were inadequate. The procedures allowed for the introduction of new and potentially dangerous activities by a single member of staff at Chief Instructor level.
- (51) Mr Pratt gave evidence of his term as Operations Director. He had many qualities to recommend him for a post, which involved the management of a centre offering residential holidays for young people. He had experience of pastoral work with young people and had worked as a manager in industry. His short comings lay in the area of outdoor activities. He was frank about his lack of relevant qualifications and experience.
- (52) I found it surprising that Mr Pratt, with his background in management, had allowed a situation to develop where he felt that the instructors were not

keeping him fully advised of all that was going on at Barcaple. I did not wholly accept his evidence on this point. I reached the view that the communication between Mr Pratt and the instruction team was poor but I did not accept that this was because Mr Pratt was being excluded. I preferred the evidence of Andy Giles and Richard Farrell, which was to the effect that they did not seek to exclude Mr Pratt. I have concluded that Mr Pratt, for some reason, did not take as active a part as he should have in keeping himself informed.

- (53) I found it equally surprising that Mr Pratt asserted in evidence that he was not aware that gorge jumping was happening at Barcaple. There was evidence that the activity featured in literature associated with the summer camps and was on the daily programmes distributed at the centre. I also heard evidence that one of his sons had been at a gorge jumping session at the second pool. I have been unable to reconcile these strands of evidence. I did not reach the view that Mr Pratt was not telling the truth on the point. I am left with the impression that Mr Pratt took insufficient care about what was happening in the outdoor activities being provided at Barcaple.
- (54) The poor quality of the risk assessment for gorge jumping and the absence of any system for recording safety concerns, supports my view that matters of safety in the area of outdoor activities were not given sufficient attention at Barcaple. The importance of keeping good records of issues concerning safety management was not given sufficient attention.
- (55) I accepted the evidence of Lorimer Gray and Dr Simpson of the Abernethy Trust that the safety procedures then in use had been intended to meet the guidance issued by the Health and Safety Executive, Crown Production 39 refers. On the issue of gorge walking, the safety standards were an effort to reflect the fact that the activity was not covered by a National Governing Body. It was not fully appreciated until the accident involving Laura, that the system allowed for the introduction of a new activity such as gorge jumping by a Chief Instructor acting alone.
- (56) I am satisfied on the evidence of Mr Gray and Dr Simpson that if the senior management team had been aware of any concern about safety at Barcaple, Stephen Spalding, the Technical Adviser, or another appropriately qualified person would have been asked to investigate and report back.

- (57) The inadequacies in the management and safety systems have been addressed in the new policies and procedures adopted by the Abernethy Trust. I have concluded from the evidence that the Abernethy Trust now operates at a satisfactory level on issues of safety.

12. The inspection of Barcaple by the regulatory bodies

- (58) I have dealt with the issue of inspection in detail in the next part of this determination.
- (59) On the facts, I heard evidence from Mr Telfer of A.A.L.A and from Mr Collins of Dumfries and Galloway Council.
- (60) Mr Telfer did not have responsibility for inspecting gorge jumping. His evidence, however, did assist me in gaining an understanding of the whole sector of outdoor activities and how A.A.L.A conducts inspections.
- (61) Mr Collins gave helpful evidence about how the guidance issued to local authorities on inspections of adventure activities had been applied by Dumfries and Galloway Council. I accepted that the Council had sought to meet its responsibilities. The regulatory scheme is complex and I found Mr Collins to be frank about the problems his department had in following what exactly was required of them.

13. Changes by Abernethy Trust to management and systems after 25th July 2006

- (62) I heard evidence from Lorimer Gray, Dr Simpson and Mr Edmondson about the changes put in place following upon the accident. I accepted their evidence that the Abernethy Trust reacted swiftly and took steps to ensure that appropriate safety measures were in place across all their centres.
- (63) I am satisfied that all these measure have addressed the deficiencies in the operations at Barcaple, which were apparent from the evidence. The circumstances which led to the introduction of gorge jumping at Barcaple and which led to Laura falling to her death should not arise again under the revised systems.

PART V: ISSUES ARISING FROM THE EVIDENCE

1. Regulatory scheme

The need for regulation and the areas of concern in the present scheme

- (1) The great majority of school children in Scotland will receive outdoor education as part of their curriculum. It was clear from the evidence before me that the challenges and stimulation that outdoor education provides are of great educational benefit. It is equally clear that there are risks inherent in the activities, which require to be kept to a tolerable level. I was advised that there are a large number of private companies and individuals engaged in providing activities in this sector. The public need to be assured that these providers are well regulated and the activities are as safe as possible.
- (2) In 1995 a licensing scheme was introduced to improve the regulation of the sector. The licensing scheme set in place a system of inspection of the safety measures in place for only certain categories of activity. Many outdoor centres provide a wide range of activities and some of those activities will fall in the scope of the scheme and some will fall out of the scope of the scheme.
- (3) The enforcement of duties under health and safety legislation was left with the existing enforcement authorities. The existing enforcement authorities were also left with the responsibility for inspecting activities out of scope of the licensing scheme.
- (4) This division of responsibilities has resulted in what was described by a number of witnesses as a “two tier” system. It would appear from the evidence that the system is more fragmented than that. Licensing and enforcement are dealt with by separate statutory bodies. There is a further division of responsibility as inspection of outdoor activities is divided between the licensing authority and the enforcement authority. The responsibility for inspection being determined by whether or not the activity falls in or out of the scope of the licensing scheme.
- (5) In the course of the Inquiry it became evident that the overlap of inspection regimes and responsibilities has resulted in certain short comings in the overall regulation of adventure activities. I would wish to observe that there was

evidence that this sector has a good safety record. Notwithstanding that, where the safety of children is concerned, any short comings merit careful consideration. Accordingly, I have considered it important to set out in summary the statutory provisions and the operation of the regulatory schemes in order to detail some of the problems in the operation of the legislation, which arose out of the evidence.

- (6) I have not set out a full exposition of the legislation or all the issues concerning regulation. Nor have I been able to identify all the short comings or problems, which may exist. I did not hear evidence of the application of the legislation across all the local authorities in Scotland. I only heard specific evidence about the inspection of Barcaple and some evidence about the other centres operated by the Abernethy Trust. I did not hear detailed evidence about the practices in the rest of the industry. In these circumstances, I have endeavoured to set out the central issues, which arose in this Inquiry and have led me to make recommendations about the need for review of the regulation of this sector.

The statutory framework

- (7) The licensing scheme was introduced following an incident at Lyme Bay in Dorset in March of 1993 in which four teenagers drowned on a canoe trip. The activity had been organised by a privately run activity centre. There was considerable public concern about the tragedy and calls were made for the further regulation of the industry.
- (8) A Private Member's Bill was put forward by the local Member of Parliament for Lyme Bay. The Bill proposed a scheme for the licensing of the providers of outdoor activities to young persons under the age of 18 years. The Bill received the Royal Assent as the Activity Centres (Young Persons' Safety) Act 1995.
- (9) Prior to the enactment of the 1995 Act, the provision of adventure activities was regulated by the Health and Safety at Work etc Act 1974 (1974 Act) and the Management of Health and Safety at Work Regulations 1992. These statutory provisions remained in place. The 1995 Act did not affect the duties imposed under the health and safety legislation. The licensing scheme introduced a further tier of regulation.

- (10) The 1974 Act and the relevant regulations impose duties on providers in respect of their clients who may be affected by their work. These duties applied to the provision of the activities at Barcaple. Amongst other duties, the provider is required to have in place:-
- (i) Safe systems of work, safe equipment and adequate maintenance;
 - (ii) Training, instruction and supervision of employees;
 - (iii) Protection for non-employees;
 - (iv) Suitable and sufficient assessment of risks;
 - (v) Arrangements for the planning, organisation, control, monitoring and review of safety measures;
 - (vi) Procedures for dealing with serious and imminent danger
 - (vii) Employee training and assessment of capabilities.
- (11) The 1995 Act was an enabling act and allowed for regulations to be passed to set up a scheme of regulation and provide for:
- (i) The setting up of an authority to license persons providing facilities for instruction or leadership in prescribed adventure activities;
 - (ii) Regulations to prescribe adventure activities, establish requirements related to safety and set out the functions of the licensing authority.
- (12) The designated authority was the Health and Safety Executive, which contracted another party, Tourism Quality Services Ltd (TQS), to run the licensing regime. The Adventure Activities Licensing Authority {A.A.L.A} was set up by TQS and the organisation began to operate the licensing regime. There followed a number of changes of the bodies involved in the regime and changes of title, which are not relevant to the events on 25th July 2006. At the time of the accident the relevant licensing authority was A.A.L.A. as operated by T.Q.S.
- (13) The Adventure Activities Licensing Regulations 1996 were the original regulations made under the 1995 Act and set in place the licensing scheme in largely the same form as it is to the present date. These Regulations defined who is required to hold a licence and provided for the appointment of inspectors. The Regulations set out four areas of activity, which were to be subject to licensing;

- (a) caving
 - (b) climbing
 - (c) watersports
 - (d) trekking.
- (14) It is likely that the four areas of activity specified in the 1996 regulations were identified as those which posed the greatest risk of multiple fatalities. The consultation and policy papers, which preceded the drafting of the Regulations, are now unavailable and the reasons for selecting those definitions cannot be ascertained.
- (15) The four areas of activity came to be referred to in the sector as being “in scope”, that is they fall within the scope of the licensing scheme. Any activity which falls out with the scope of the scheme is referred to as being “out of scope”.
- (16) The licensing scheme aimed to give assurance that good safety management was in place. Any provider of adventures activities, falling within the four categories above, to persons under eighteen years of age requires a licence for those activities. A licence is only granted after inspection by the licensing authority and only where the provider has been able to demonstrate compliance with health and safety legislation and that they operate in accordance with nationally accepted good standards of practice.
- (17) The role of the licensing authority is to issue licences. The licensing authority has no statutory enforcement powers and no immediate power to prevent an activity from continuing.
- (18) The enforcement responsibility for any breaches of the applicable health and safety legislation remains with the relevant enforcing authority. In this instance that is the local authority, Dumfries and Galloway Council. I will confine my consideration of the operation of the statutory schemes to the situation where a local authority holds that responsibility. The different arrangements under the legislation for the appointment of other enforcing authorities are not of importance in relation to the issues before this Inquiry.

Guidance issued to A.A.L.A and the Local Authorities on the Adventure Activity Licensing scheme

- (19) The introduction of the licensing scheme introduced an overlap of responsibilities for ensuring health and safety in the adventure activity sector. The licensing authority and the enforcement authorities were issued with guidance and advice on the approach to be taken on the issue of this overlap.
- (20) The Health and Safety Executive issued guidance to A.A.L.A following the introduction in 1996 of the licensing scheme. This guidance was the subject of regular review and at the time of the accident the applicable document was Guidance on Regulations L77, Crown Production 37 refers. That guidance stated at paragraph 75:

“75. The licensing authority should cooperate with the health and safety enforcing authorities. A memorandum of understanding should be agreed between them setting out the detail of areas of responsibility; avoidance of overlap; liaison arrangements and speedy contact in cases of evident serious concern”.
- (22) The Health and Safety Executive and the Local Authorities formed a liaison committee (HELA) and issued circulars to give local authority enforcement officers advice on the effects of the licensing scheme. The applicable circular in July 2006 was Local Authority Circular 47/15 (LAC 47/15), Crown Production 36 refers. The subsequent circular LAC 47/21, Crown Production 47 refer, is in largely the same terms.
- (23) In LAC 47/15 advice on inspection was given at paragraph 28 where it stated:

“28.Duplication of inspection activity providers by both the AALA and the LA enforcement officers should be avoided”.
- (24) Circular LAC 47/15 also advised local authorities that under the demarcation of responsibilities they held responsibility for the activities, which were not licensable activities. Local authorities were advised that there should be contact with A.A.L.A to agree demarcation and to plan visits to providers *“to minimise the burden on the business”*. There was also guidance given that where a provider offered activities which were *“all or predominately subject to AALA”*, namely in scope for the regulations, inspections should be confined to reactive work.

The operation of the inspection regime by A.A.L.A

- (25) A Memorandum of Understanding was entered into between T.Q.S, the company in charge of managing the A.A.L.A., and the Health and Safety Executive for the enforcement authorities. This understanding set out again that both organisations were to avoid unnecessary duplication of effort, ensure effective co-ordination and ensure a free exchange of information.
- (26) The A.A.L.A set in place an inspection scheme to ensure that providers of adventure activities were meeting the safety requirements set out under health and safety legislation. The A.A.L.A. appointed inspectors with relevant qualifications in the sphere of outdoor activities.
- (27) The inspections for a licence are conducted on an annual basis. The provider has to specify in the application for the renewal of a licence, which in scope activities are provided. There is no requirement on a provider to detail all the activities provided. A licence is only granted following a satisfactory inspection. The licence is issued only in respect of in scope activities.
- (28) The inspection visit is usually conducted in the course of one day. The inspectors have the power to consider all activities provided at a centre both in and out of scope. The inspectors have the opportunity to view a limited number of activities given the length of their visit.
- (29) There has been little communication between A.A.L.A with local authorities on the issue of inspection.

The operation of the inspection regime by Local Authorities

- (30) The local authorities in Scotland, including Dumfries and Galloway Council, appoint Environmental Health Officers (EHO's) to conduct inspections to ensure that the provisions of the health and safety legislation are being complied with. The inspection scheme extends to the providers of outdoor activities, which are out of scope for licensing by the A.A.L.A. The EHO's are not given specific training for inspections of outdoor activities.
- (31) Local authorities are not advised by providers of the activities engaged in at their facilities. There is no system in place to ensure that a local authority is made aware of the adventure activities, which are not the subject of inspection by A.A.L.A and for which the local authority retains responsibility for inspection.

- (32) Local authorities receive guidance by circulars on the type of inspection programmes to be operated by them. The applicable circular in July of 2006 was LAC 67/1, Crown Production 60 refers. The circular sets out a rating system to assess the level of hazard posed by premises or operations. The different levels of hazard will determine the frequency of inspections. Over time, the rating system can result in premises being graded in a band for lower levels of hazard. For premises graded in the lower bands, the inspection is less frequent.
- (33) The rating system can result in premises only being inspected in reaction to reported incidents or concerns, rather than on a planned and regular basis. At the lowest level of hazard, the premises would fall within a band where an alternative enforcement strategy is in place and would not be subject to inspections.
- (34) In the main, local authorities have not had contact with A.A.L.A to agree demarcation and plan inspection visits. The inspections by EHO's and A.A.L.A have not been co-ordinated. There has been little communication between A.A.L.A. and the authorities.
- (35) A number of Local Authorities have not appreciated that their responsibilities for enforcement in relation to adventure activities extend to activities conducted out with the premises of the provider. The relevant provision is Regulation 2 of the Adventure Activities (Enforcing Authority) Regulations 2004/1359, Crown Production 57 refers.

2. Problems with the regulatory scheme identified in the course of evidence

The categories of activities

- (36) As referred to above, the reasons for the introduction of four categories of adventure activity is unclear. It is likely that the four categories were intended to cover all the activities associated with a risk of injury or death. The definition by reference to the four categories has not kept pace with the range of new activities introduced.
- (37) The outdoor activity sector has seen the introduction of great deal of new activities. Many of the new activities do not fall within the four categories but may have equivalent levels of risk. The system of categorising by the nature

of the activity rather than by the level of risk present does not appear to serve a useful function now.

- (38) The purpose of the licensing scheme was to extend regulation and allay public concerns about young people taking part in dangerous activities. It is unlikely to have been the intention of the legislature, when enacting the 1995 Act, that potentially dangerous activities could be introduced without a licence and subject to a less rigorous inspection scheme.

- (39) The long title of the Activity Centres (Young Persons' Safety) Act 1995 states that it is -

“An Act to make provisions for the regulation of centres and providers of facilities where children and young persons under the age of 18 engage in adventure activities, including provision for the imposition of requirements relating to safety.”

The title and the long title both express that the central purpose was the regulation of centres and providers. The licensing system as it now operates depends upon the nature of the activity and not the risk that may be present in a wide variety of adventure activities. The licensing scheme does not appear to serve the purpose of the Act.

- (40) In the present instance, gorge jumping is not in scope unless it is part of an activity which also includes, for instance, a piece of climbing involving the use of a single pitch by rope, in which case it will be covered by the category of climbing. It follows that it is possible that at an adventure activity centre gorge jumping could be in scope one day and out of scope the next. This example demonstrates the limitations of the present system of categories.

Difficulties arising from the overlap of responsibilities

- (41) The guidance given by LAC 47/15 on the issue of inspection is not set out in clear terms and has the potential to be confusing. It is stated that there should not be duplication of inspection then states that the local authority retains responsibility for inspection for the out of scope activities. This position is further qualified by the statement that the local authority is only to conduct reactive inspections where a provider is predominately offering activities covered by A.A.L.A.

- (42) From the evidence before me it appears that a number of local authorities have read this guidance as enjoining them not to inspect providers in respect of adventure activities where A.A.LA inspections are conducted. This presents the possibility that out of scope activities may not be inspected at all. Out of scope activities presently include activities such as gorge jumping and the use of indoor climbing walls, each of which can involve an element of risk. It is not satisfactory that such activities are not the subject of inspection.
- (43) Dumfries and Galloway Council were not aware that the Regulations extend their responsibilities to activities conducted out with their boundaries by a provider based within their boundaries. This may well be a wide spread misunderstanding. It is an example of the way in which the operation of a fragmented scheme has been difficult to follow in practice and has allowed errors to be made.
- (44) In the present scheme, a provider is only required to advise the licensing authority of the activities, which are in scope. There is no obligation for a provider to advise anyone about the provision of out of scope activities. As the circumstances at Barcaple in July 2006 demonstrate, this allows for the situation where the licensing authority and the enforcement authority do not know an activity is being undertaken.
- (45) A further difficulty with the present scheme arises from the fact that the inspection of out of scope activities has been subsumed into the general policy on inspections by local authorities. The guidance on that policy directs local authorities to work to a rating system, which could result in a provider not being subject to planned inspections. From the evidence before me from the senior Environmental Officers, Mr Collins and Mr Dunn, it was clear that in many areas this has happened and there is very limited inspection undertaken of adventure activity centres by local authorities.

Lack of liaison between AALA and the Local Authorities

- (46) The guidelines issued by HSE to both of these bodies specified that there was to be discussion and agreement between them on issues of demarcation and cooperation. Whilst a formal Memorandum of Association was entered into between them, the evidence before me was to the effect that there has been only minimal communication between them.

- (47) The lack of any proper liaison may well have contributed to the present situation where both the local authority and A.A.L.A. were unaware that gorge jumping was going on at Barcaple.

Lack of expertise of environmental health officers in outdoor activities

- (48) The inspectors working for the licensing authority have been recruited from the outdoor activities sector.
- (49) Environmental Health Officers are very well qualified and well trained in a number of areas, which are relevant to the bulk of the work they undertake. It was clear from the evidence that EHO' do not receive specific training for inspecting adventure activities. I was advised in evidence by Mr Collins and Mr Dunn that EHO' do not consider themselves qualified to inspect many of the out door activities being provided at centres.
- (50) Adventures activities present particular risks and problems. To assess the safety management and systems in place, an inspector will require sufficient knowledge and experience in that field. As the system operates just now, EHO's lack the necessary skills to conduct inspections of a number of the out of scope adventure activities, which fall within their sphere of responsibility.

3. *Training and accreditation of Instructors*

- (115) The Crown raised this issue both in evidence and in submissions. It was the submission of the Crown that there was merit in providers being required to provide a written methodology for use by their staff in the conduct of any activities. It was also submitted that accreditation of instructors as approved to conduct an activity should be have a set procedure or methodology.
- (116) The submissions by the Crown have some merit, namely that a written methodology would highlight to instructors what was of expected of them when conducting an activity and ensure that they were properly accredited. A system for accreditation could promote consistency in standards. The systems in place at Barcaple at the time of the accident demonstrated the danger of instructors passing down information by word of mouth only and the difficulties of consistency in approach for accreditation.
- (117) On the other hand, there was evidence from Mr Telfer that there were drawbacks in having written methodologies. Adventure activities take place in

the outdoors where conditions and circumstances can vary a great deal. It is important that instructors assess the risks as they are at the time of an activity, a process referred to as assessment of a dynamic risk. There was concern expressed that written methodologies might lead to rigid adherence to those instructions and reduced emphasis on the dynamic risk. The view was also expressed that there was a good standard of training in the sector and that set procedures for accreditation were not required.

- (118) I have not been persuaded that this is an area in which I have heard sufficient evidence to allow me to reach a concluded view and make specific recommendations. It would be more appropriate that this issue be part of a review of the regulation of the sector. This will allow for a range of information to be presented by those persons and institutions with the requisite experience in adventure activities.

PART VI : RECOMMENDATIONS AND REASONS

RECOMMENDATIONS

1. That a comprehensive review be undertaken by the Health and Safety Executive of the statutory scheme for the regulation of the provision of adventure activities to persons under the age of 18 years set up under the terms of the Activity Centres (Young Persons' Safety) Act 1995 and the regulations of 1996 and 2004 made under that act. The review should commence as soon as reasonably practicable and should address, amongst any other relevant issues, the following;
 - (i) Whether any licensing scheme should be administered by a single authority and if so, which authority should have that responsibility;
 - (ii) Whether any licensing scheme should encompass all the adventure activities engaged in at the facilities operated by providers rather than specific categories of activity;
 - (iii) Whether or not local authorities should retain the responsibility for the inspection and enforcement of the statutory requirements for health and safety in relation to adventure activities;
 - (iv) If the regulation of providers of adventure activities is to be administered by separate authorities, what system can be put in place to ensure effective demarcation of responsibilities and liaison between the authorities;
 - (v) The guidance given to any licensing or enforcement authorities on their duties to inspect the providers of adventure activities to young persons;
 - (vi) The training and level of qualifications appropriate for persons involved in the management and delivery of adventure activities to young persons.

2. That the Health and Safety Executive require all providers of adventure activities requiring a licence under the Activity Centres (Young Persons' Safety) Act 1995 and the Adventures Activities Licensing Regulations 2004, to include in any application for a licence details of all adventure activities provided to persons under the age of 18 years. This requirement should be introduced without delay.

3. That the Health and Safety Executive issue clear guidance to local authorities on the extent of their statutory responsibilities under health and safety legislation for the inspection of providers of facilities for adventure activities to persons under the age of 18 years. This guidance should be issued without delay.

4. That the Health and Safety Executive review the present guidance and advice to local authorities contained within Local Authority Circular 47/15 and Local Authority Circular 47/21 and issue a further circular or circulars containing clear guidance on the responsibility of local authorities for the inspection of adventure activities engaged in by young persons, where such activities fall out with the inspection scheme of A.A.L.A. This review should be conducted as soon as is reasonably practicable,

Reasons for the recommendations

General

- (1) The introduction of gorge jumping at the second pool at the Grey Mare's Tail followed upon an error of judgement by a member of staff at Barcaple. That person was not suitably qualified or experienced enough to assess the risk to participants. The activity continued up until the accident because the safety management systems in place at Barcaple were not sufficiently rigorous to ensure that the earlier assessment of the risk was reviewed and the activity halted. Further, there was no system in place to ensure that action was taken following upon the expression of concerns about safety.

- (2) I am satisfied that the Abernethy Trust has now conducted a thorough and comprehensive review of its safety and management procedures. There is little possibility within the Abernethy Trust of the recurrence of the circumstances, which led to Laura and other young persons taking part in an activity with an unacceptable level of risk of serious injury or death. It follows that I do not consider that it is in the public interest for me to make any recommendations regarding the management and operation of its undertakings by the Abernethy Trust.
- (3) Barcaple was subject to inspection under the licensing scheme for certain activities provided and held a licence from the A.A.L.A.. The activity in which Laura was engaged was not subject to the licensing scheme administered by the A.A.L.A.
- (4) The activity was subject to a scheme of inspection by Dumfries and Galloway Council who did not have a complete understanding of their responsibilities and had no knowledge of the activities being undertaken at the centre. As the centre was inspected by A.A.L.A., the Council interpreted the guidance from the HSE as an indication that a scheme of planned inspections was not necessary.
- (5) The A.A.L.A and Dumfries and Galloway Council did not liaise over the inspection of Barcaple and there had been no discussion about how to organise their separate responsibilities for inspection for the same premises.
- (6) The tragic circumstances of the death of Laura brought to light these difficulties and shortcomings in the operation of the regulatory scheme. The gaps in that scheme led to gorge jumping not being the subject of inspection. It is an issue of public concern that other children could be exposed to unacceptable levels of risk by engaging in unsuitable adventure activities, which are also not subject to inspection.
- (7) The HSE recognise that concern and in evidence and in submissions indicated that they would welcome support in my determination for a review of the whole regulatory scheme. Accordingly, I have made recommendations, which it is to be hoped will result in a review of the regulation of adventure activity centres and providers. I have made further recommendations to put in place measures to ensure the present scheme operates as well as it can in the meantime.

- (8) Any proposals for changes to a complex regulatory scheme would require to flow from a full consideration of all the legislation and widespread consultation with interested parties. I did not consider that it was the function of this Inquiry to set out what, if any, detailed changes should be made to the legislation. The evidence was directed to the circumstances of the death of Laura. The matters I heard in evidence were, by necessity, restricted to the purpose of this Inquiry. For those reasons, I have recommended a comprehensive review of the regulatory scheme and steps that can be taken within the parameters of the current legislation rather than any specific changes to the legislation.

Recommendation 1.

- (9) I heard evidence from Gavin Howat, Inspector of Health and Safety, who is employed by the Health and Safety Executive. He has specialised in the regulation of adventure activities within the Health and Safety Executive and has a wealth of experience in the sector.
- (10) Mr Howat advised the Inquiry that H.S.E. now has the responsibility for the A.A.L.A. The H.S.E. is entitled under Section 3(4) of the 1995 Act to submit to the relevant Minister proposals for the making of regulations under that act. He advised that the H.S.E. has reached the view that the whole structure of the regulatory scheme requires to be reviewed and it is their intention to conduct such a review.
- (11) The H.S.E. has recognised that the existing scheme has created an overlap of responsibilities for licensing and enforcement and has not provided a satisfactory scheme of regulation. The H.S.E. will consider the removal of the division of responsibilities for inspection and enforcement and whether both responsibilities should lie with one statutory body.
- (12) Mr Howat advised that H.S.E. is concerned that the definition of adventure activities has not been flexible enough to encompass a number of new and potentially risky activities. He indicated that in future it is likely that the focus would be on the providers of the activities who are managing the risks rather than by any defined categories of activity.
- (13) The evidence brought to light that the management of safety issues at Barcaple prior to the accident was inadequate. I am not clear what the position is as

regards the safety procedures operated by other organisations. For that reason, I have reached the view that it would be in the public interest for the H.S.E. to consider in the review, the training and qualifications of all those who are engaged in the provision of adventure activities..

- (14) I am satisfied that a comprehensive review by the H.S.E. is an appropriate way to address the concerns about the legislation, which arose in this Inquiry. Under this recommendation, I have detailed certain matters that merit attention. It is not an exhaustive list and there may well be other areas of concern, which were not ventilated in evidence.
- (15) It is to be hoped that the review will be commenced in early course given that the legislation is intended to protect the safety of young persons and given the number of young persons who participate in adventure activities.

Recommendation 2.

- (16) Any review of the statutory scheme will take time. Mr Howat gave evidence that the H.S.E. are able to issue directions to the A.A.L.A to require applicants for licences to detail all adventure activities provided by them. This does not require any change to the legislation and can be done right away. I have reached the view that the immediate introduction of this requirement would be a useful measure pending any proposals to change the licensing system. It might prevent other young persons engaging in adventure activities of which the A.A.L.A and the local authority are unaware.

Recommendation 3.

- (17) There is a clearly a need for local authorities to be made aware of their responsibilities for inspecting adventure activities under existing health and safety legislation. I was advised in evidence by Mr Howat that a circular can be issued by HSE with this information. It is to be hoped that this can be done in early course. A review of the inspection schemes may result in an improved scheme. In the meantime, parents are entitled to expect that the safety of their children will be regulated under the health and safety regulations as presently enacted and with all the safeguards provided for in those regulations.

Recommendation 4.

- (18) I have also recommended that the HSE redraft Local Authority Circulars 47/15 and 47/2, which issue guidance on the inspection of adventure activities. It was clear that even senior and experienced environmental health officers, such as the witnesses Mr Collins and Mr Dunn, have been unsure on how to apply the guidance. This appears to be the experience of many of their colleagues in other local authorities. Albeit this area may be affected by changes following a review, I consider that in the meantime it is of considerable public interest that the inspection of adventure activities out with the scope of the licensing scheme is as effective and thorough as possible.
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I wish to acknowledge the considerable care and attention shown by the legal representatives in the course of the Inquiry. I was grateful for their sensitive and sympathetic approach to the examination of the evidence. It was of great assistance to have all the issues thoroughly explored and to have detailed submissions at the conclusion of the evidence.

In conclusion, I wish to extend my deepest sympathy to the family for their loss. Laura lost her life in the most tragic of circumstances. It may be of some comfort to her family that the Health and Safety Executive intend to review the scheme, which failed to protect Laura. It is to be hoped that every effort will be made to ensure that the safety of young persons engaged in adventure activities is assured by rigorous and effective regulation in the future.

Sheriff Johanna Johnston, Q.C.

Kirkcudbright, 24th June 2010