water safety Scotland

Preventing Future Fatalities

Improving Water-Related Fatality Data in Scotland

Development of this document

This document was developed by the Data Subgroup of Water Safety Scotland, which is chaired by RoSPA.

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Abstract

In Scotland, there is currently no formal requirement for a systematic review of accidental drowning fatalities. This document brings together information on the current legal landscape and explores potential solutions to help prevent accidental water fatalities in Scotland.

Introduction

Drowning is a serious public health and community safety issue that affects families and communities across Scotland.

This document focuses specifically on accidental drowning fatalities, but is also relevant to unintentional injuries, such as those caused by accidents in the home and during leisure activities. The document considers the present context, challenges with the current law and the impact upon data collection, epidemiology and victims' families.

On average, 50 people accidentally drown each year in Scotland and a further 29 people take their own lives at or near water.[i]

South Queensferry Lifeboat on training, RNLI

The current data

Drowning is a serious burden both within the United Kingdom and globally. The cost of one drowning death in the UK is estimated at £2.8 million.[ii]

Scotland carries a disproportionate rate of drowning in comparison to the rest of the United Kingdom – in fact, almost double the UK average.[i]

It is encouraging, however, that a recent report by The Royal Society for the Prevention of Accidents (RoSPA) shows that the number of accidental drowning fatalities is decreasing.[iii] In 2018, there were 46 accidental drowning fatalities[1] in Scotland – an 8 per cent decrease in comparison to Scotland's Drowning Prevention Strategy's baseline (see Figure 1).

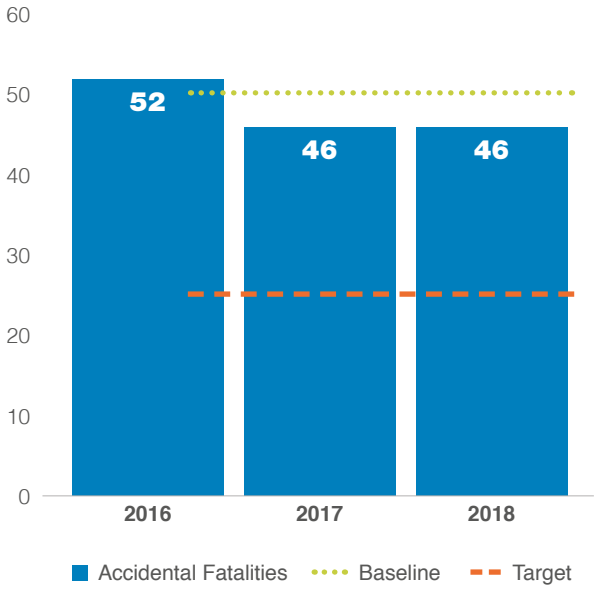


Figure 1: Accidental drowning fatalities by year (2016–2018) vs Scotland's Drowning Prevention Strategy baseline (2013–2015)

This data comes from WAID (Water Incident Database), which is a web-based system created by members of the National Water Safety Forum (NWSF) and held by RoSPA. It has been created to collect data from various sources, including emergency services and inquest reports. It merges them into one single incident record, which can then be analysed. Recent work in Scotland has compared the drowning fatality statistics to official National Records of Scotland data with high accuracy, demonstrating the reliability and validity of the WAID system.[2]

Although Water Safety Scotland cautiously welcomes the decrease in water-related fatality statistics, there have been 46 water-related fatalities over the past three years that were classified as "unknown".[iii] This means that it was unclear whether the fatality was due to crime, suicide or accidental causes.

1 Fatalities due to suspected accidental and natural causes.

2 Pre-publication: available on request.

Global and national strategies

Water Safety Scotland launched Scotland's Drowning Prevention Strategy in January 2018. The strategy has two overall targets:

- Reduce accidental drowning deaths in Scotland by 50 per cent by 2026 and reduce risk among the highest-risk populations, groups and communities
- Contribute to the reduction of water-related suicide.

The strategy goes into further detail, providing six key aims to help meet these targets. One of these aims focuses on data and exploring the "opportunities to work collaboratively following an incident to ensure all lessons are learned". This document is the first step towards achieving this.

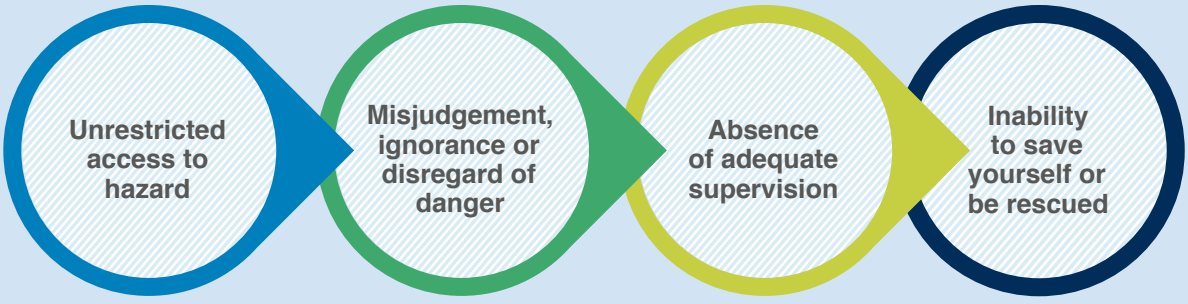
Globally, this work also complements the World Health Organization's (WHO) recommendation that "All countries should take steps to improve data about drowning".[iv]

The drowning chain

> "Drowning is the process of experiencing respiratory impairment from submersion/ immersion in liquid."[v]

Drowning can be fatal or non-fatal.

The drowning chain is a series of conditions that individually or together can lead a person to fatally drown.



Data and intelligence permit the analysis of a drowning fatality and the specific factors which led up to the incident. This can provide important information as to where the drowning chain could have been broken and the life saved. This intelligence can then be used to create measures to break the drowning chain and prevent future fatalities from occurring. For example, measures such as restricting access to a dangerous reservoir, providing lifeguards at a hazardous beach or providing appropriate public rescue equipment for rescue, can all help break the drowning chain.

The policy context

Scotland's National Performance Framework has an overall purpose – *"To focus on creating a more successful country with opportunities for all of Scotland to flourish through increased wellbeing, and sustainable and inclusive economic growth".*[vi]

Drowning prevention is a key issue within public health and community safety.

Scotland's Public Health Priorities[vii] were published in 2018 with one key priority relevant for drowning prevention – *"A Scotland where we live in vibrant, healthy and safe places and communities".* This concept of "safe" links well to the current Justice Strategy, which has an overall vision for a safe, just and resilient Scotland.

Place is a key concept for both justice and health in Scotland. Place can help achieve better outcomes for communities and people. The places where we are active need to be safe for people and free from high drowning risk.

The Royal College of Paediatrics and Child Health (RCPCH) released a policy response for Scotland to the *State of Child Health Report 2017* and called on the Scottish Government to implement "a robust, consistent child death review system for Scotland by 2018".[viii]

The Scottish Government committed to the establishment of a new national approach for child death reviews by 2020 in *Delivering for Today, Investing for Tomorrow: The Government's Programme for Scotland 2018-19.*

Child Death Reviews are multi-agency and examine the circumstance of every child death. This means that every drowning fatality up to the age of 18 would be explored in a multi-agency setting.

The purpose of the national Child Death Review process is to systematically:

- Improve communication with families
- Gather accurate information and implement consistent reporting of the cause and manner of each death
- Identify significant risk factors and trends to be disseminated locally and/or nationally; and inform Scottish Government policy in order to reduce the number of child deaths
- Identify and alert implications for others and/or for future births
- Improve inter-agency responses in the investigation and structured review of child deaths.[ix]

The function of the review system proposed is to review the circumstances surrounding each death in a nationally uniform manner, and in a collaborative, inquisitorial, multi-agency and "no blame" approach.

The RCPCH is currently calling for the age of the proposed national Child Death Review process to be increased to 26 for all deaths. Water Safety Scotland supports this call, as there has been a number of drowning fatalities within this age group. For example, WAID data shows that there were 49 accidental water-related fatalities among those under the age of 26 in the past five years, compared to 17 among those up to age 18.[x]

The challenge in Scotland

The legal landscape

In Scotland, there is currently no formal requirement for a systematic review of accidental drowning fatalities. The Child Death Review process is underway, but the lack of Fatal Accident Inquiries means that the in-depth data and intelligence required to help prevent accidental drowning fatalities is not available.

The Procurator Fiscal oversees all investigations into fatalities in Scotland. The Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 states that the Procurator Fiscal has a mandatory duty to investigate a fatality and hold an inquiry (known as a Fatal Accident Inquiry) if the fatality occurred in Scotland and happened in employment, in legal custody, or was a child in secure accommodation.

All other potential Fatal Accident Inquiries, such as those relating to accidental drownings, are not automatically in scope and are at the sole discretion of the Lord Advocate.

Fatal Accident Inquiries into drowning fatalities are uncommon, with exceptions such as the Loch Awe investigation in 2011. Last year, there were 41 Fatal Accident Inquiries in Scotland.[3] It is unclear if any of them were for a drowning fatality, as this data is not routinely published.

Year	FAIs
2018/19	41
2017/18	53
2016/17	41
2015/16	46
2014/15	66

Table 1: Fatal Accident Inquiries concluded per year.[3]

Fatal Accident Inquiries into other forms of unintentional injury are also rare – one notable example being the inquiry in 2009 by Sheriff David Mackie into the death of a two-year-old from strangulation by a blind cord.

The cost of a Fatal Accident Inquiry is unknown. Last year, however, the Procurator Fiscal spent £11,898,000 to investigate deaths which required further explanation (which would have included the Fatal Accident Inquiries held during the period 2018/19).[xi]

3 Data provided by the Crown Office and Procurator Fiscal Service, via a freedom of information request dated 09/08/2019.

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016

What the Act says:

Section 2: Mandatory inquiries

An inquiry is to be held into the death of a person which—

(a) occurred in Scotland, and

(b) is within subsection (3) or (4).

(2) Subsection (1) is subject to section 3.

(3) The death of a person is within this subsection if the death was the result of an accident which occurred—

(a) in Scotland, and

(b) while the person was acting in the course of the person's employment or occupation.

(4) The death of a person is within this subsection if, at the time of death, the person was—

(a) in legal custody, or

(b) a child required to be kept or detained in secure accommodation.

Section 4: Discretionary inquiries

(1) An inquiry is to be held into the death of a person which occurred in Scotland if the Lord Advocate—

(a) considers that the death—

(i) was sudden, suspicious or unexplained, or

(ii) occurred in circumstances giving rise to serious public concern, and

(b) decides that it is in the public interest for an inquiry to be held into the circumstances of the death.

(2) Subsection (1) does not apply to a death within section 2(3) or (4).

Comparisons with other legal systems

Scotland's system of discretionary Fatal Accident Inquiries is similar to those of some other countries, such as Northern Ireland and the Republic of Ireland. However, other legal systems within the UK and the wider Commonwealth make inquests for unintentional fatalities mandatory and therefore allow for data and intelligence around drowning prevention to be gathered. For example, both England and certain states within Australia make specific reference to unintentional injuries and unnatural deaths in their legal framework for inquests (see Appendix 1 for an overview of various countries' stances on inquests with regard to unintentional injury).

England and Wales, in particular, have the ability to capture more data and intelligence due to the set-up of the investigation of fatalities. Coroners are employed through the local authority to investigate fatalities. Changes to the law resulted in the Coroners and Justice Act 2009, which essentially places a **statutory duty** on coroners to investigate "unnatural deaths", including unintentional fatalities such as drowning incidents. An investigation must involve an inquest. Prior to this, inquests were discretionary.[xii]

Coroners and Justice Act 2009 – England and Wales

What the Act says:

(1) A senior coroner who is made aware that the body of a deceased person is within that coroner's area must as soon as practicable conduct an investigation into the person's death if subsection (2) applies.

(2) This subsection applies if the coroner has reason to suspect that—

the deceased died a violent or unnatural death,

the cause of death is unknown, or

the deceased died while in custody or otherwise in state detention.

(6) Duty to hold inquest

A senior coroner who conducts an investigation under this part into a person's death must (as part of the investigation) hold an inquest into the death.

The benefits of an inquest

There are many benefits to an inquest being held. An inquest provides opportunities for the family to ask questions and gain accurate facts about the deceased. It can also help rescue workers understand the full circumstances of the death.

The impact of a drowning

When a person drowns, the impact is greater and wider than the immediate family who have lost a child, sibling, parent, spouse or grandparent/grandchild. It affects whole communities, the dead person's friends, colleagues and everyone who uses the same area of water. To those not affected by the loss of a close friend or relative in a water fatality, there is an assumption that some form of review of the reasons for a death in water would be explored and lessons learned to reduce the chance of further deaths.

It is vitally important to relatives of drowning victims that other families do not suffer a similar fate. Every time a water death is reported this brings back the sense of loss and can trigger the despair felt at the time of original loss.

There is currently no consistent or formal mechanism in Scotland to assess the circumstances surrounding each death by drowning. No routine inter-agency reviews or intelligence gathering take place. A lack of information and feedback leaves bereaved families at a significant disadvantage in understanding the last minutes of their loved one's life. In addition to the pain of loss, many affected by the drowning of someone close endure the additional anguish of not understanding the full picture e.g. who was involved in trying to rescue or resuscitate. It is especially important for bereaved families to know that attempts were made to save their loved one and that measures are being taken to avoid future deaths.

A rescue worker's experience

Rescuers attend coroners' inquests in differing capacities. Sometimes we attend as subject matter experts, providing insight into how the environmental conditions would have had an impact on somebody losing their life. Sometimes we attend in order to provide the coroner with an understanding of what prevention measures are in place to prevent a recurrence of the incident. On other occasions, rescue workers attend because the inquest process provides the benefit of closure.

The main priorities of an inquest are to establish:

- Who the person was
- When they died
- Where they died
- The circumstances of their death.

Most of the focus of an inquest concentrates on the circumstances surrounding the death. Rescuers are usually only involved post-incident and, despite efforts, there is sometimes very little we could have done to prevent the person from dying. The impact and self-blaming aspect of this can be difficult for a rescuer to deal with.

An inquest really helps this by providing details of how that person ended up in the situation. It can sometimes help workers realise that, in some circumstances, their efforts would not have changed the outcome. This is crucial for the mental health of rescuers after the incident.

Importantly, an inquest allows lessons to be learned and formally captured. An example of this can be found in England under Rule 28 and 29 of the Coroners (Investigations) Regulations 2013[xiii], in which coroners have a duty to decide how somebody came by their death but also, where appropriate, to report on ways to prevent future deaths.

This helps to draw attention to an area of concern and allows other organisations to take forward the information and provide recommendations to help prevent future deaths.

An example of where this has been put into practice is in Durham. See case study: Durham.

CASE STUDY

Durham

Durham is a historic city that lies on the River Wear in County Durham. There were three high-profile fatalities over the course of 18 months from October 2013 to March 2015, as well as a further 56 water-related incidents from 2010 to 2015.

The first fatality in October 2013 resulted in an inquest in which the coroner raised a number of concerns under Rule 28 and 29 of the Coroners (Investigations) Regulations 2013.[xiii] Although further fatalities occurred within the 2013 to 2015 timeframe, Durham County Council set up Durham City Safety Group and adopted a multi-agency approach in response to the coroner's concerns.

An independent review was then commissioned to consider the council and other landowners' strategic safety procedures around open water.

The review resulted in Durham City Safety Group implementing a number of safety measures, including:

- Engineered improvements, including improved barriers in key sections of the riverbank
- Improved lighting and a safe route campaign to help people get around the city safely at night
- Increased provision of public rescue equipment at key positions
- Several awareness-raising campaigns
- Working with licensed premises to implement improved guardianship and responsible retailing.

Since the implementation of these safety measures, there have been no unintentional drowning fatalities in the city centre.

The concerns raised by the coroner, through their statutory duty, was an important factor for the implementation of these preventative measures.

Discussion and conclusions

Understanding the key factors which led up to a fatality is essential in order to help prevent future fatalities occurring. Water Safety Scotland argues that every single drowning fatality should be investigated. There are three main options to ensure this happens.

The first option is to make an amendment to the current law in Scotland, specifically the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016. This would bring Scots law in line with current practices in England and Wales, and other countries such as Australia, and would allow for the data and intelligence required to be gathered in a systematic and appropriate way. The cost of this is recognised, and with roughly 50 accidental drowning fatalities in Scotland each year, a substantial increase in resources would be required to ensure they are all investigated.

The second option is to introduce a statutory review process, such as the Child Death Review process, which could be put in place for drowning fatalities. Water Safety Scotland supports recent calls from RCPCH to increase the age of the Child Death Review process to 26. This would allow for all drowning deaths of children and young people to be systematically investigated. Such an official process would be critical for improving drowning prevention, as it would facilitate the consistent gathering of data and the identification of contributory factors. Lessons can therefore be learned and consideration given to preventative measures and controls.

The third option is to create a voluntary review process, led by the Scottish Government or Crown Office and Procurator Fiscal Service, which is specific to water-related fatalities. This would be similar to the second option, although it would be voluntary as opposed to statutory, and would be applicable to all drowning fatalities, irrespective of age.

Water Safety Scotland argues that a top-down approach to data is necessary in order to capture all drowning fatality data and intelligence, and recognises that all three of these options have merits. In the meantime, whilst a relationship is built with the Crown Office and Procurator Fiscal Service and amendments to law are considered, Water Safety Scotland will pilot a voluntary review process through its current membership by the end of 2021.

To conclude, this paper has shown that systematically reviewing all drowning fatalities has huge potential to support prevention and save lives in the future. Lessons need to be learnt from past incidents and fatalities.

Appendix 1

Countries and their laws relating to inquests

Country	Act	Section	Key point of Act	Water Safety Scotland interpretation
Scotland	Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016	Section 2	An inquiry is held if the person died at work, in care or in custody.[xiv]	Discretionary
England and Wales	Coroners and Justice Act 2009	Part 1, 1 (2)	Coroners have a statutory duty to investigate *"unnatural deaths" including unintentional fatalities.*[xii]	Mandatory
Northern Ireland	Coroners Act (Northern Ireland) 1959	Section 13 (1)	Coroners may hold an inquest and inquire into deaths reported to them for a number of reasons, including an accident.[xv]	Discretionary
Republic of Ireland	Coroners Act, 1962	Part 3, 17	Coroners' duty to hold an inquest if they are *"of opinion that the death may have occurred in a violent or unnatural manner, or suddenly and from unknown causes".*[xvi]	Discretionary
New Zealand	Coroners Act 2006	Part 3, 60	Coroner must open an inquiry if death is self-inflicted or in care/custody.[xvii]	Discretionary
Australia				
Australian Capital Territory	Coroners Act 1997	Part 3, 13 (1)	Coroner must hold an inquest if a person *"dies after an accident where the cause of death appears to be directly attributable to the accident".*[xviii]	Mandatory
Tasmania	Coroners Act 1995		Coroner must hold an inquest if death is a homicide, in custody, care or an accident at work. Coroner *"may hold an inquest into a death which the coroner has jurisdiction to investigate if the coroner considers it desirable to do so."* [xix]	Discretionary
Queensland	Coroners Act 2003	Part 3, 27. Reportable death Part 1, 8 (3)	Coroner must hold an inquest if death is in custody, care, or is a reportable death, e.g. *"the death was a violent or otherwise unnatural death".*[xx]	Mandatory
Victoria	Coroners Act 2008	Part 4, 15. Reportable death Part 1, 4 (2)	Coroner must investigate a death if it happened in Victoria, within 50 years, and is a reportable death, e.g. *"a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury".*[xxi]	Mandatory
Western Australia	Coroners Act 1996	22 (1)	Must hold an inquest for a death in care or custody.[xxii]	Discretionary
New South Wales	Coroners Act 2009	Division 4, 27 (1)	Inquest is required to be held for a number of reasons, including homicide, but not unintentional injury.[xxiii]	Discretionary
South Australia	Coroners Act 2003	Part 4, 21 (1)	Coroner must hold an inquest for a number of reasons, including *"a fire or accident that causes injury to person or property".*[xxiv]	Mandatory
Northern Territory	Coroners Act 1993	Part 4, 15	Coroner must hold an inquest for numerous reasons, but unintentional injury is not included (unless in care/custody).[xxv]	Discretionary

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