Good practice guide

Managing inland waterway safety risks

Foreword

This good practice guide discusses the reasons and motivations for managing risk to members of the public who visit Britain's inland waterways. Understanding the risks experienced by visitors is the key to their effective management. The assessment of risks by industry professionals using best available information and data will provide this understanding and the sound basis on which to make judgements on what, if anything, needs to be done. There is no single 'correct' way of performing a risk assessment. It is important that each navigation authority institutes methods that suit its own organisation and this guide is designed to help achieve this.

However, assessing and controlling risk is not just something for the navigation authority to be concerned about – visitors, their representative bodies and other stakeholders should also be involved and AINA encourages all navigation authorities to take a lead in building partnerships to address visitor safety.

Occasionally, accidents and incidents do occur. When they do it is vital that navigation authorities investigate causes and learn lessons in order to inform their risk assessments and help to avoid recurrences. Simple and concise guidance on incident reporting and investigation is also presented in this document.

This guidance will be supplemented from time-to-time by further guidance on specific topics, the first of which, on tree management, is referred to in this guide.

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AINA Chairman

June 2015

Association of Inland Navigation Authorities

About AINA

[PB to supply]

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1. Introduction

1.1 Risk has been and always will be an important and essential part of everyday life. Each day we make judgements which balance desired goals or benefits against the chance that something undesirable (a risk) will happen on the way to achieving these objectives. These judgements can range from the mundane (Do I really need to carry an umbrella today?) through the routine (Shall I cross this busy road now?), and to the very specific (I want to take up mountain walking, but do I have the skills and equipment to manage the risk?).

1.2 For all the large range of risks experienced in our lives we have become more aware in recent years that with some planning and forethought it is possible to enjoy the benefits of activities without having to take the chances that were the norm only a few years ago. Put another way, we are now much better at recognising and controlling risk. This applies especially to recreational activities. So for example, water sports now appeal to more participants as people have perceived that the chances of major injury have reduced through improved design and availability of craft, equipment and training. In taking part the participant decides that the benefits obtained such as improved physical and mental well-being, outweigh the risk of harm. There is also an increasing recognition that the visitor has to exercise self-reliance and not expect a risk-free experience. These changed perceptions have also led to the risks associated with water sports and recreation being more acceptable to society at large.

1.3 The examples mentioned above apply to cases where the control of the risk and decisions whether to participate are largely in the hands of the individual. However, many activities in our increasingly complex society are not entirely in the control of the individual. We frequently rely on organisations to manage risks on our behalf and increasingly have come to expect risks to be managed for us down to ever-lower levels, hence increasing the perceived level of safety. As a society we are have become increasingly intolerant to having risks (whether real or imagined) imposed upon us.

1.4 Reducing or avoiding risk usually comes at a cost which can be expressed, not only in monetary terms, but also in terms of loss of amenity (perhaps caused by over-zealous application of safety controls), restrictions of access (risk avoidance by barring access), and denial of opportunity (by setting preconditions such as qualifications).

1.5 The uses of inland waterways are subject to these trends and changes just as much as any other activity in everyday life be it travelling to work by train, adventure holidays, sports, or any other recreational activity.

1.6 The tragic loss of life on the Marchioness river boat in 1989 led first to the 1992 Hayes Report into river safety and subsequently to the 1999 Thames Safety Inquiry (TSI) held by Lord Justice Clarke. Whilst the Inquiry was confined to the tidal Thames in London, Lord Justice Clarke drew attention to the relevance of a number of his 46 safety recommendations to other inland waters in the UK. The TSI, together with a number of drownings in the capital and elsewhere on the inland waterway system, led to a government review[1] and the setting up of the National Water Safety Forum[2] . The Forum draws together stakeholders across the range of water-related leisure activities in the UK to achieve a balanced and consistent approach to water safety through defining good practice and learning from the accidents and incidents which do occur.

[1] Inland Water Safety: Roles and Responsibilities, Department for Transport, Local Government and the Regions, July 2001.

[2] www.nationalwatersafety.org.uk

Other pressures have come from the main regulators (Health and Safety Executive, and the Maritime and Coastguard Agency), from trading standards (especially on craft standards), and from the increasing tendency of 'victims' of accidents to seek compensation.

1.7 Management of visitor risk presents challenges which are very real and need to be addressed, but it is important to approach them positively and to regard them as providing opportunities to promote and sustain inland waterways as a shared, sustainable resource for a variety of leisure and recreational activities, in particular for use as navigations. By doing so, the further and wider potential of inland waterways for assisting urban and rural regeneration, tourism and commercial activities, the conservation of the natural environment and built heritage, transport and freight, water resources and other uses can be realised.

1.8 AINA recognises the trends and pressures outlined above and the need for navigation authorities to be able to present a consistent approach to their management. AINA is committed to sharing data on accidents and incidents amongst its members and encourages its members to contribute their accident and incident data to the Water Incident Database (WAID) operated by the National Water Safety Forum (NWSF).

1.9 AINA is grateful to the Department for Environment, Food and Rural Affairs (DEFRA) for its support for this review and updating of this report, first published in 2003.

1.10 The guidance in this document is structured as follows:

Section 2 discusses why visitor risk management is a topic that navigation authorities need to deal with.

Section 3 discusses the application and relevance to inland waterways of the NWSF Water Safety Principles and the 'Guiding Principles' produced by the Visitor Safety in the Countryside Group.

Section 4 discusses the planning and management issues vital to successful visitor risk management.

Section 5 reviews the experience of some AINA members in planning and managing visitor risk management and suggests ways in which other navigation authorities could take these issues forward.

Section 6 discusses the essentials of accident and incident reporting and investigation and identifies the core elements which navigation authorities should adopt.

1.11 It should be noted that throughout this document the term 'visitor' is taken as meaning anyone not employed by the navigation authority (on a paid basis or as a volunteer) who either visits a waterway for pleasure or work, or for whom it forms part of their everyday environment.

1.12 In writing this document every effort has been made to base its guidance on sound basic principles which are not expected to change substantially. Reference is made to various documents produced by other parties, including safety regulators, which are subject to periodic review or change. This should be borne in mind when using the guidance.

2. Why address Visitor safety?

2.1 There are several reasons why navigation authorities should take a positive and proactive approach to managing user safety:

The legal framework

2.2 The legal status of the various navigation authorities differs greatly. AINA Members include the three large navigation authorities – the Canal and River Trust, the Environment Agency, the Broads Authority – and also local authorities, drainage commissioners, property development companies, port authorities, original waterway companies, national parks, the National Trust and other charitable trusts. The law, as applied to these very different types of organisations, can be divided into two types - criminal and civil, which are discussed in greater depth in Appendix 1.

Managing increasing public expectations

2. 3 As indicated in the introduction, the public often expect environments where risks have been 'managed out'. The inland waterways environment, in common with many other environments, is such that it is not possible to make them risk-free. Navigation authorities therefore need a way of identifying risks and then deciding on what controls, if any, are appropriate. These may require communication with visitors to make them aware of those hazards which the authority cannot reasonably control itself.

Managing resources

2. 4 There is virtually no limit to the measures that a navigation authority could put in place, given the resources, to manage visitor risk. Risk control programmes could take the form of major engineering works such as new bridges or rebuilt embankments, public information, schools awareness exercises, signs or barriers. Whether desirable or not, these can be costly to implement and resources can be severely limited. A structured approach to user risk management will help ensure that available resources are channelled to best effect, and that hasty, ill-considered reactions to particular events are avoided. Where resources can only permit the introduction of measures at some future date then risk management can help justify this phasing and show that all that is 'reasonably practicable' is being done. A good assessment of risk can also be a powerful tool when seeking additional sources of funding for projects where safety is an issue.

Balancing safety, heritage and the environment

2. 5 Doing what is 'reasonably practicable' in terms of controlling risk involves taking a balanced judgement between the benefit in terms of reduced risk and the adverse effects in terms of costs, restrictions to access, or reduced health and well-being benefits. In a waterways environment it is usual to find other types of potential adverse effects, namely to the protection and sustainability of the built and natural environment, each of which is protected by its own legislation. Therefore, it is entirely possible to find these different sets of objectives each with its own legislation acting in conflict with each other. It is quite legitimate to take account of heritage and environment considerations when making the type of cost/benefit decision required by the HSW Act. There will however be occasions when the respective regulators will need to be engaged in the decision making process. The collective experience of the major navigation authorities shows that acceptable compromise can usually be reached.

Good risk management processes are of considerable help in showing that the arguments have been considered in a consistent and rational way. They also enable visitors to experience the health and well-being benefits of waterways at an acceptable level of risk.

Managing incidents

2.6 In even the best managed organisations it is quite possible that at some stage something will go wrong and a serious incident will occur. The more serious the event the greater will be the degree of external scrutiny given to the organisation's management arrangements. In extreme cases this can (and has in well-known instances outside the waterways environment) result in organisations losing control of their business when they appeared to have no grasp of the issues or the ability to deal with them. A sound approach to visitor risk management puts organisations in a much stronger position to be able to defend what it did (and perhaps more importantly, didn't do) to manage the events or circumstances leading up to the incident.

Business reasons

2.7 All navigation authorities are seeking to increase the resources available to them to maintain, improve, or develop the assets under their control for the public benefit. Inevitably this requires external stakeholders to become engaged, be they waterway users, local communities, funding agencies or government. They are far more likely to become engaged rather than isolated if they perceive that visitor safety is being managed in a consistent and professional manner rather than just as a reaction to events.

Moral reasons

2.8 Finally, putting aside the, mainly practical, reasons given above, there is a strong moral case for visitor risk management. The waterways will always carry a degree of risk and as those with responsibilities for their management, maintenance and use, navigation authorities do not want to see people come to harm where such incidents could reasonably have been avoided.

3. Basic Principles

3.1 The original version of this guidance drew on the work carried out by the Visitor Safety in the Countryside Group (VSCG), in particular its 'Guiding Principles'. Upon its formation in 2005 the National Water Safety Forum (NWSF) used the VSCG Principles as the basis of its own set of principles adapted to the more aquatic environments of its members. The resulting NWSF Water Safety Principles are summarised here and reproduced in full in Appendix 2. Many navigation authorities will be responsible for managing non-aquatic assets so it is recommended that navigation authorities keep abreast of VSCG developments especially through their publications[3] and website. There are many types of visitor issues that navigation authorities need to deal with; indeed some of VSCG's founding members are also AINA members. Typical of the visitor risk management challenges facing navigation authorities are:

- Encouragement of visitors
- Reconciling visitors needs with management of work sites
- Multiple access points often offering legitimate access at all times
- Wide range of visitor activity, sometimes conflicting
- Extensive responsibility for land and property
- Limited resources
- Little or no direct supervision of visitor activity by staff
- Conflicting demands of conservation, natural and built environments, safety, heritage, open access and quality of the visitor experience.

3.2 In summary, the Principles are intended to enable members to comply with modern risk management requirements without adversely affecting the attraction that brings the visitor in the first place. This is done in large part by recognising that all stakeholders have responsibilities and a role to play.

3.4 The main headings of the Water Safety Principles are shown below and have been applied in formulating the best practice advice set out in this guide. The Principles are set out in full in Appendix 2

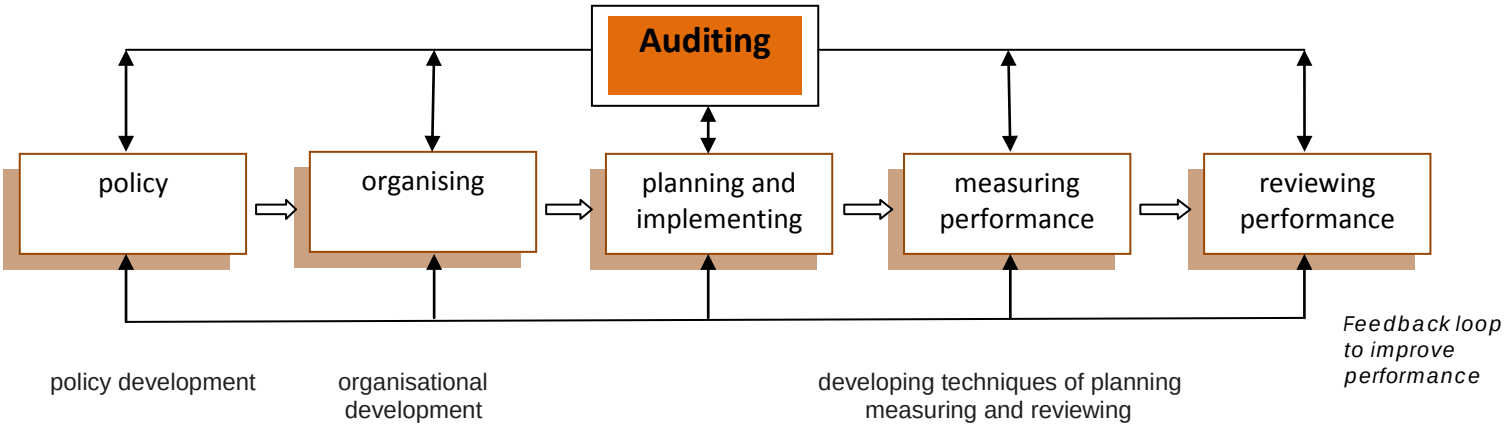
- Fundamentals
- Responsibility
- Partnership
- Awareness
- Competence
- Communications

[3] Managing Visitor Safety in the Countryside – Principles and Practice.www.vscg.org.uk

4. Planning for visitor safety

4.1 As with most other things, successfully implementing visitor risk management is achieved most effectively and efficiently by the appropriate amount of pre-planning. What is 'appropriate' will very much depend on the scale of individual navigation authorities' undertakings and the resources available to them. Nevertheless, there are some basic steps to follow which navigation authorities can adapt to suit their own circumstances. In general these follow the model set down by HSE in its document, *Successful Health and Safety Management* but with some adaptation to suit the particular circumstances of visitor risk management. The elements of the HSE model are shown in the Diagram 1. They follow well-established principles of business management.

Diagram 1



Visitor Safety Plans

4.2 A visitor safety plan is essential whatever the size of the navigation authority and resources available to it. Similarly, a clear management strategy and good planning are essential to achieving its objectives. Section 2 outlined the management motivation for managing visitor risks. In order to achieve these aims planning is required to:

- Demonstrate organisational commitment. The active and tangible support of senior management is required at board, trustee, or executive level as appropriate to the organisation. It is highly unlikely that you will succeed without it. This must be the first objective.
- Identify resources. Be clear on what you can and can't do and who has responsibility.
- Direct available resources to best effect. Even in the larger national organisations resources are invariably limited and in competition with other objectives. Give priority to those schemes that are most cost-effective in terms of achieving acceptable levels of risk.

An effective plan will:

- Clearly show the commitment of management at the most senior level
- Integrate visitor risk management with other policies and activities especially those for employee safety and environment.

- Set out your goals and what you plan to do to achieve them
- Be inclusive of the views of visitors and their representative groups.
- Help achieve consistency of approach to hazards across the authority.

Visitor safety should not be treated as an add-on. Rather, it is just one aspect of managing a waterway environment successfully.

Elements of a visitor safety plan

4.3 It is helpful in meeting the needs identified in Section 2 if a navigation authority's approach and arrangements for visitor safety can be set down in a 'Visitor Safety Plan'. Whether, and how this is done will depend on the size of the navigation authority, its exposure to visitor risk and the resources available. So the form of a visitor safety plan can vary from a purpose-written document to inclusion of the appropriate elements in the written health and safety policies required under the HSWA, as appropriate to the organisation.

4.4 Whatever is appropriate, organisations are advised to consider including the following elements in the visitor safety plan:

Management structure

4.5 This considers how the navigation authority is set up to deal with visitor safety issues. This should address all the interfaces and communication channels with visitors and all other stakeholders. It is in the nature of visitor risk management that there are many stakeholders with different perspectives and responsibilities. An open and inclusive approach is essential if a balanced response owned by all stakeholders is to be achieved.

4.6 Navigation authorities should consider carefully the breadth of their interests; these will not necessarily be aligned with strict legal responsibility. For example, it will not be unusual for an authority to have responsibility only for regulating navigation and to have no responsibility for property beyond the water's edge other than, say, warning of unsafe structures. If the navigation authority wishes to promote the use of its waterway either directly or through the waterway's potential as a catalyst for waterside regeneration, then it needs to engage those stakeholders who do have this responsibility.

Visitor profile

4.7 This is the navigation authority's knowledge about the make-up of its users and the activities undertaken. Good relationships with stakeholders, especially where there are groups representing visitors' interests, can yield information of which the navigation authority would otherwise be unaware.

Accident data overview

4.8 Section 6 discusses the ways in which the collection of information on accidents and incidents poses special challenges compared with occupational risk, and then goes on to discuss collection and analysis from the potentially large range of data sources. The National Water Safety Forum hosts extensive information on accidents and incidents involving water. The available information should be used as far as possible to help develop a view on visitor risk for your navigation authority and the extent to which it could or should be reduced. Depending how confident one is in this information, whether local or national, it could be used as a performance indicator.

Acceptability of risk

4.9 Navigation authorities with sufficient data on accidents and incidents can use these together with results of risk assessments to make comparisons with other business sectors (especially leisure and transport) and judgements against the criteria used by HSE for acceptability of risk. This can be very helpful in putting the risks associated with navigation and other leisure uses of the waterways into context with other activities commonly undertaken by society at large.

The National Water Safety Forum publishes reports on the risk levels for water-related activities and how these compare with other activities and criteria.

Risk assessments

4.10 Section 5 discusses this topic in more detail. However, navigation authorities should be clear in their plans for undertaking risk assessments. Risk assessments should take account of the need for stakeholder involvement, the skills and knowledge of operational staff, and especially the understanding of risk from the perspective of the inexperienced visitor. Local knowledge and experience is usually the key to visitor risk assessment but there may be a need to consider some wider issues across the inland navigation sector.

Risk control

4.11 It is quite common for organisations to have developed sets of risk control measures dealing with specific activities or visitor needs. As well as physical measures such as barriers, these can also include communication strategies such as printed risk awareness material, education programmes, and signs. These are all candidates for specific mention in visitor safety plans. Paragraphs 5.6 to 5.9 give further guidance on this.

‘Issues’

4.12 It is in the nature of user risk management that decisions on appropriate courses of action can be difficult and will require further information and investigation before a final view can be taken. It is perfectly valid to treat these investigations, or ‘issues’, as outstanding pieces of work in their own right, and to plan for their resolution accordingly. It is advisable to keep sufficient information to be able to demonstrate that issues have not been overlooked or forgotten.

Monitoring, audit and review

4.13 The need for these processes is similar to any other area of management. They provide the information by which progress against plans can be checked and problems identified and corrective action taken. They also provide management with the assurance that programmes are being implemented to plan, or, should this not be the case, that changes to strategies or resource allocation may be required.

Programmes and records

4.14 Regardless of whether a navigation authority intends to produce a written visitor safety plan, it is strongly recommended that formal records of the following items be made. Visitor safety programmes take time to implement fully but written programmes and records can demonstrate achievements and commitment to future work. Navigation authorities should consider including the following:

- Programmes for carrying out risk assessments. These should be prioritised in order of the sites considered to pose the greatest risk. This is considered further in Section 5.
- Where decisions have been made to implement risk control measures - be they 'hardware' such as barriers, or user awareness programmes – navigation authorities should show plans for when they are to be carried out and that resources have been allocated.
- Your continuing programme of work includes the 'issues' still requiring further investigation before decisions on appropriate control measures can be taken.
- Records of assessments, reviews and implementation of risk controls.

4.15 All these items will be of significant help to navigation authorities in demonstrating (especially to safety enforcement authorities) that they are doing all that is reasonably practicable to manage visitor risks. They can also build confidence with other stakeholders.

5. Risk assessment and management

5.1 The assessment of risk is a cornerstone of modern health and safety management. As stated in the introduction to this document the process of assessing risk and evaluating the need for risk control is an intuitive life skill. As navigation authorities, what we need to do is apply this basic skill in a more systematic way so that we can demonstrate to ourselves, our stakeholders, and to regulators that we have been thorough in the way we manage risk.

5.2 There are no prescribed 'easy' or 'best' methods to carry out risk assessments. To use the words from the HSE safety management regulations[4], the assessment must be 'suitable and sufficient'. Taken back to its basics the risk assessment process must use the essential elements of information, knowledge, and expert judgement available to identify those things that could cause harm, and how likely this harm is to come about. The elements are then used to reach judgements on appropriate risk controls. The role of the method is no more than to capture these essential elements of information, knowledge and expert judgement in a way that is helpful and constructive.

5.3 The method chosen must therefore suit the navigation authority. To help with this choice, this part of the guidance document looks at some of the key elements of the risk assessment and control process and how these could be adapted for application by individual navigation authorities.

What are the risks?

5.4 The first element of assessing risk is to identify those things that could lead to harm. It is suggested that this be done by considering the incidents that can reasonably be foreseen at particular locations, and then going on to consider what factors led up to the incident. Thus for example, it is foreseeable that at a particular lock site someone might fall into the lock through tripping up over a badly maintained coping, possibly resulting in that person being drowned.

5.5 The second element of risk is to estimate the likelihood of this happening. So, in the example in the previous paragraph it might be estimated that the drowning is extremely unlikely although it may be known that people may have tripped and fallen into the lock but managed to get out. The assessor must then take a view on how significant this risk is. A simple method for capturing these judgements is given in Diagram 2 overleaf.

[4] Management of Health and Safety at Work Regulations

Diagram 2. Planning and assessment flowchart

Assessment Procedure

Before Visiting Site

Review:
• Copies of previous assessments
•Reports/records of incident/accident or near misses
•Emergency callout logs
•Legal agreements for specific activities or use
•Recent press cuttings or magazine articles
•Heritage or environmental listings or issues

Identify:
•Staff or others with specific knowledge of the site
•Known activities and impacts they may have

Question:
•Imput from relevant user groups

Whilst on Site

Look for:
•Evidence on the levels and types of use
•Things that characterise the Waterfront
•Things that characterise use
•Risk Factors e.g. fast or deep water, crowd pressure, adverse inclines
•Language barriers (visitors who speak no English)
•Types of use and users present
•Any issues or conditions that could affect users

In addition:
Speak to users and adjacent residents or businesses their knowledge of the site could be different from ours

On completion of the site visit

•Review notes of the site visit
•Record significant findings
•Decide on the need for further risk control
•If you are unable to reach a decision Seek advice

Record:
•Any outstanding issues with a note of responsibility for and timescale for resolving
•Any critical decisions, they may help if challenged on reasons for actions or omissions
•Outstanding works - prepare a programme for their completion

Review

All risk assessments must be reviewed periodically. Once completed the form should be signed and dated with a planned date for review.
This may vary between a periodic review and when there are any significant changes to the site or its use

Deciding on appropriate risk controls

5.6 Unlike occupational safety where there is a wealth of information and guidance available, there is less available on visitor safety to aid a navigation authority. Decisions on appropriate risk controls (if any) are therefore not easy. For this reason it is recommended that risk assessment (what are the risks now?) and risk control (What, if anything should we do about them?) are dealt with separately. To do otherwise may further confuse an already difficult process.

5.7 AINA encourages and promotes industry best practice. Examples include the application and use of Waterway Standards, and the Boat Safety Scheme, both of which incorporate good management practice with regard to safety. Where risk control measures are not obvious or cannot be implemented for some time it is perfectly reasonable to record these planned actions as the response to that risk. Risk assessment and control is a dynamic process!

5.8 Typical examples of risk control measures include:

- Installing lock ladders
- Removing hazards likely to cause people to trip eg loose copings
- Informing boaters of navigation hazards through cruising notes.
- Fencing high-risk water control structures.
- Painting bollards
- Signs
- Publicity programmes (e.g. leaflets etc.)
- Education programmes

5.9 Risk controls need to be considered on a cost-benefit basis. That is, risk controls should not be introduced where the cost (in environment and amenity terms, not just money) exceeds the benefit. Again, there are no hard and fast rules for carrying this out. However, the fact that, as navigation authorities, we have the expertise in this area adds considerable weight to our judgements. It should also be remembered that higher risks demand more attention before costs and benefits can be said to be in balance.

5.10 The management of any given hazard should be treated consistently within the authority and take account of any published industry guidance; for example AINA's tree safety guidance.

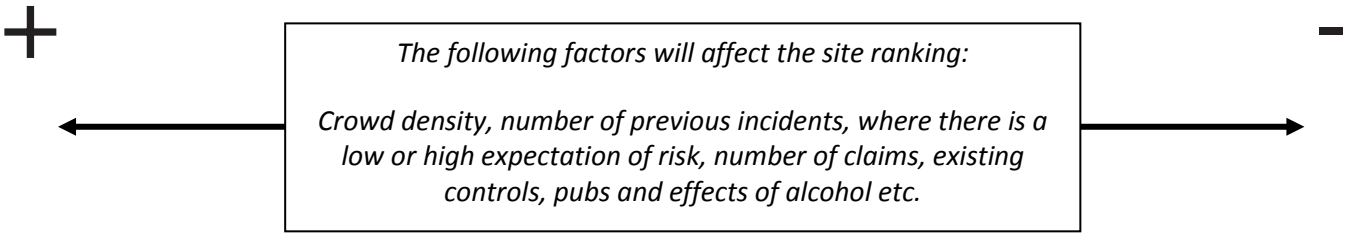
5.11 In considering the introduction of risk controls, take full account of the likely effects on other persons who may be affected. One person's risk control should not be another's hazard.

Which sites shall I look at first?

5.12 Risk assessments and decisions on risk control take time. Navigation authorities' areas and range of operation are usually large in comparison to the staff and other resources available to carry out these assessments. It is therefore necessary to prioritise the order in which the work is done. This should be based on accident/incident history, visitor numbers and areas where the duty of care to users is particularly high – at visitor centres or honeypot sites for example. Above all, the judgement of the navigation authority as to where the biggest risks lie will shape the plan for completion. An example of a priority matrix applicable to navigation authorities is given in Diagram 3.

Diagram 3: Site prioritisation matrix

Category 1 e.g.	**Category 2** e.g.	**Category 3** e.g.	**Category 4** e.g.
• Boat lifts • City centre sites • Sites adjoining schools etc • Mechanised locks (user operated)	• Locks • Aqueducts • Marinas • Moving bridges • Museums • Machinery	• Low risk moorings • Fixed bridges	• Rural towpath and navigation with no special features



5.13 It is very important to remember that a single site may encompass any one or more of the assets identified above, however a site assessment should consider all those in the predefined site boundary.

6. Accident reporting, recording and investigation

6.1 Incident reporting and investigation are important elements in managing visitor safety. All navigation authorities want their users to enjoy their waterway experiences and return home unharmed. It is important to learn from accidents and incidents that do occur.

6.2 However, getting the information is not that easy. Millions of visits are made each year to sites with open access, often with no on-site management. Finding out about accidents and incidents, learning from them and communicating the lessons is a major challenge.

Why investigate incidents?

6.3 It is important to investigate accidents and incidents in order to:

- manage the risks to our visitors. It is important to identify the causes of accidents and near misses so that we can consider any measures that might prevent them happening again. This is a key element of any risk management strategy.
- fulfil any statutory requirements. Some accidents to the public must be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995 (see below for specific details). Some accidents involving boats on inland waterways are reportable under the Merchant Shipping (Accident Reporting and Investigation) Regulations. (see below for further details).
- provide information in case there is a claim for compensation or a need to defend against legal action
- identify trends in the pattern of incidents
- identify changes in the use of a facility
- monitor how safety performance is changing

Common obstacles to reporting and investigation

6.4 The collection of accident/incident data is not easy – these are some of the common obstacles:

- Difficulty in collecting information. This is especially relevant to navigation authorities managing large water bodies and/or unmanned or isolated sites.
- Fear of blame. It is important to create a management culture that encourages staff and users to report accidents and incidents.
- Over-complicated reporting systems. It is important that reporting systems are clear and simple.
- Staff may be unaware of the value of the information they supply. It is important to give feedback and show how things have changed as a result of an investigation.
- Visitors may not know how or where to report incidents.

6.5 Overcoming such obstacles will require time and effort and the implementation of a simple reporting procedure for staff and users.

Once the procedure has been designed and (where possible) prior to implementation, user groups should be consulted to obtain their feedback and support for the process. Improved reporting at unmanned sites can be achieved through education and liaison with users and, where practical, the provision of a contact number for reporting incidents immediately.

6.6 The Canal and River Trust has developed a process whereby visitors can report incidents either by completing a form or texting details of an incident. The form can also be used to report incidences of vandalism or threatening behaviour. Details are on their web site at http://canalrivertrust.org.uk/contact-us/visitor-incidents.

The form can be found on line at http://canalrivertrust.org.uk/media/library/1180.pdf.

Procedures for reporting under RIDDOR

6.7 The main aim of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) is to provide enforcing authorities with information on specific injuries, diseases and dangerous occurrences arising from work activities. However, there is a legal requirement to report to the enforcing authority certain accidents where a member of the public is taken to hospital or killed. The enforcing authority is either the Health and Safety Executive or the environmental health department of the local authority. There is some guidance on this point on HSE's web site (OC124/11 Appendix: Health and Safety (Enforcing Authority) Regulations 1998: A-Z guide to allocation). In general, canal operation is allocated to HSE for enforcement, although note that commercial boat hire is more likely to fall to the local authority for enforcement. Correct allocation of enforcing authority is important following the introduction of HSE's charging regime ("Fee for intervention") and the fact that it does not apply to local authority enforcement.]

6.8 In circumstances where a member of the public is killed or is injured and taken to hospital, then having considered paragraph 6.9 below, the navigation authority should:

- Inform the enforcing authority of the incident as soon as practicable, usually by reporting on-line. Full details can be found on HSE's web page at http://www.hse.gov.uk/riddor/report.htm. There is also a telephone service for reporting serious incidents in working hours, and an out-of-hours number for the most serious incidents (given at http://www.hse.gov.uk/contact/outofhours.htm).
- Follow up the original report within ten days by submitting a completed accident report form (F2508) to the enforcing authority.

6.9 Deciding whether RIDDOR applies in particular circumstances can be difficult. You do not have to notify the enforcing authority in every instance where a visitor is injured on your property and taken to hospital for treatment. Accidents are only reportable if:

- they arise out of, or in connection with, work **and**
- the injury **necessitates** the removal of a person from the site of the accident **directly** to hospital for treatment.

6.10 HSE guidance on RIDDOR explains the phrase "arising out of or in connection with work". The phrase has a wide meaning, defined by three key factors that should be taken into account when deciding what to report:

- "the manner of conducting an undertaking" – i.e. the way in which a work activity is carried out, including how it is organised, supervised and performed
- "the plant or substances used for the purposes of the undertaking" – i.e. any machinery, equipment or installation or any substances used in connection with the premises or with the processes carried on there
- "the condition of the premises" – including the structure or fabric of a building or outside area forming part of the premises and the state and design of floors, paths, paving, stairs, lighting etc.

6.11 The word "premises" has a wide meaning. It could be a property like a house, gardens and parkland. It encompasses facilities such as toilets, playgrounds, forest walks and car parks. It can include canal towing paths and riverbanks and includes infrastructure such as roads and footpaths, locks and bridges.

6.12 The mere fact that a user sustains an injury on a navigation authority's property that requires him/her to be taken to hospital for treatment does not necessarily make it reportable under RIDDOR. The accident must have arisen in connection with your activities or be in some way attributable or the condition of your premises. This may include the provision of facilities for recreation opportunities and access to the countryside for members of the public. Therefore, the application of RIDDOR needs interpretation in a waterway setting.

6.13 Each case needs to be considered on its own merits. Take, for example, an injury sustained by slipping on wet grass. If the injured person was running down a hill in open countryside, it is unlikely that the accident would need to be reported. If the person slipped on an urban towpath or official access, it may have resulted from a failure to provide or maintain an adequate path. If so, reporting would be necessary. If in doubt, it is always possible to discuss the need to report with the enforcing authority or someone familiar with such situations.

6.14 Diagram 4 below, is intended to help ensure that accidents to members of the public are correctly reported. It suggests a framework that can be adapted by navigation authorities to suit their own circumstances.

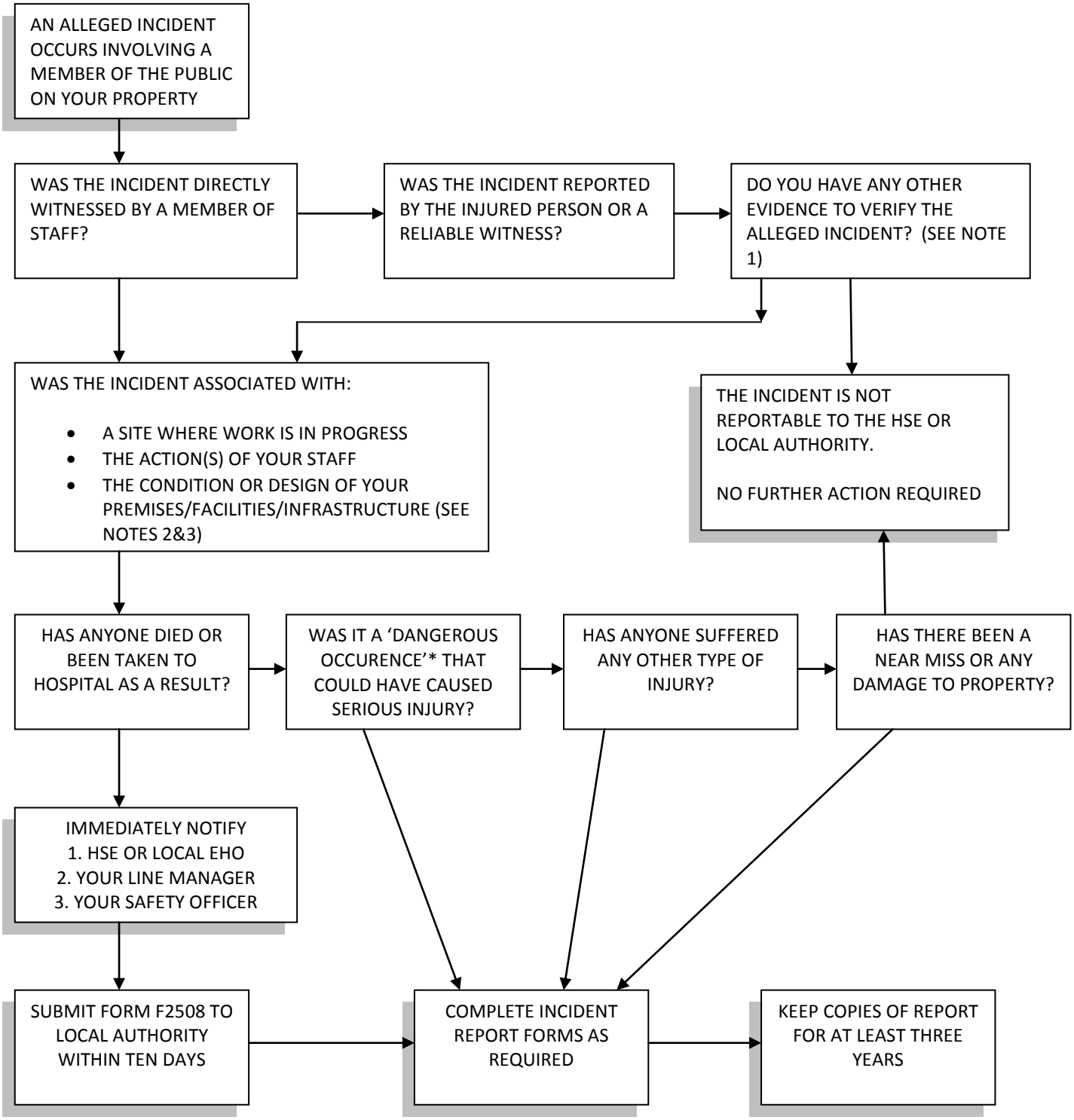
6.15 Navigation authorities must also keep a record of any reportable injury. This must include the date and method of reporting; the date, time and place of the event, personal details of those involved and a brief description of the nature of the event. Records may be kept in any form, for example by:

- keeping paper copies of report forms in a file
- recording the details on computer
- maintaining a written log

6.16 The incident report form included as Appendix 4 may be used or amended by navigation authorities as appropriate for the purpose of keeping records.

6.17 In the interests of maintaining an authoritative record of incidents across all navigation authorities, you are also strongly advised to enter your incident data into the National Water Safety Forum's Water Incident Database (WAID). To contact the NWSF, go to their website http://www.nationalwatersafety.org.uk/waid/.

Diagram 4. Reporting incidents involving members of the public (under RIDDOR)



* Generally related to workplace activities – see RIDDOR for details

Note 1: When the source of the report is other than by a direct witness (for example, a newspaper report) it would be reasonable to make basic enquiries to determine whether the incident has occurred. This can be difficult, since hospitals are unlikely to release information to anyone other than close relatives. Give careful consideration to issues such as liability and possible litigation before making contact with the injured person or family.

Note 2: On occasions, an inquest may reveal that an incident, previously unreported, was associated with one or more of these factors. If so, you should report the fatality to the relevant local enforcing authority (HSE or local authority). If the coroner has recorded an 'open' verdict but there is significant evidence that the fatality was intentional, the incident is NOT reportable.

Note 3: The meaning of "premise/facilities/infrastructure" is considered in paragraph 6.11.

Investigation procedures

6.18 Any incident that actually or might have caused serious injury to a visitor should be investigated. Incidents need investigating in greater depth if:

- someone was, or might have been killed or seriously injured
- similar incidents could occur elsewhere
- considerable damage has been done to property or to the environment
- the accident was reportable under RIDDOR

6.19 Someone with appropriate competence and expertise should carry out the investigation. Smaller organisations with limited safety expertise in-house may need to bring in an external adviser to carry out an independent investigation. Your internal procedures should consider when to involve insurers or legal advisers after a serious incident. You should also consider whether the incident could give rise to media enquiries and how these would be handled.

An accident investigation report

6.20 Many organisations have special forms for reporting accidents and recording the findings of an investigation - often the two are combined. Typically they gather the following information:

Basic Facts:

- what happened (details of incident)
- where it happened (location, canal, river, lock, weir etc.)
- when it happened (date & time)
- how it happened (immediate causes)
  - facilities or equipment involved
  - the weather
  - the physical characteristics of the site
  - the activity involved
- who was involved
- name and address of the reporting organisation

Evidence:

- any photographs or video recording
- witness statements

Evidence should be gathered before any changes are made to the site, and whilst the incident is fresh in people's minds. When gathering evidence, reporting should be factual and speculation on what happened should be avoided. Where there are no eye-witnesses or where the evidence is not conclusive, words such as "alleged" can be used when recording the incident details.

Accident history:

- has a similar accident happened before?
- were recommendations made at the time to prevent a recurrence?
- were the recommendations carried out?

Causes:

- immediate
- underlying

6.21 The immediate cause of an accident may be equipment failure. The underlying causes may be lack of maintenance and inspection or lack of training and supervision. These are often concerned with the quality of an organisation's systems and procedures.

6.22 The report should include recommendations, i.e. actions to reduce the likelihood of a similar incident recurring, or to reduce the severity of the consequences.

6.23 The Incident Investigation Report (see Appendix 5 for sample form) may be used or amended by navigation authorities as appropriate. Provide succinct but detailed information when completing the form.

Review

6.24 There should be a review after a specified period of time to see if the recommendations have been implemented, and to assess whether they were adequate and appropriate.

Procedures for Reporting under Merchant Shipping regulations

6.25 The scope of the Merchant Shipping (Accident Reporting and Investigation) regulations[5] applies to accidents occurring to vessels in UK waters. 'Accident' is defined broadly and encompasses outcomes ranging from loss of the vessel or fatalities to near-misses, as well as environmental pollution.

6.26 Navigation Authorities have a duty to report accidents and serious injuries to the Chief Inspector of Marine Accidents and investigate and report on the circumstances, including making recommendations to prevent a recurrence. This duty to report does not apply to:

[5] Marine Guidance Note 458, www.maib.gov.uk

1. Pleasure vessels[6]
2. Recreational craft hired without skipper or crew
3. Any other craft or boat, other than one carrying passengers, in commercial use and less than 8 metres long.

In the case of 2 and 3 the duty to report still applies where the accident involves any of:

- Explosion
- Fire
- Death
- Serious injury
- Capsize of a power-driven craft or boat
- Severe pollution

Refer to footnote 5 for more information on reporting.

Note that incidents involving pollution of water courses are also reportable to the Environment Agency.

[6] Defined as any vessel wholly owned by individuals and used only for their sport or leisure or that that of their immediate family or friends, or, owned by a corporate body and only used by employees or their immediate family or friends for sport or leisure.

Appendix 1

The Law and visitor safety

This appendix looks at the law relevant to visitor safety and refers to cases brought under health and safety legislation and judgements made in the civil courts. It can only provide a broad overview of the law and should not be a substitute for proper legal advice in specific circumstances. The outcomes of many cases will usually depend on the particular circumstances, and may not necessarily establish general principles.

Section 2 introduced the legal framework as one of the main reasons why navigation authorities should take a positive and proactive approach to managing visitor safety. The law as applied to navigation authorities can be divided into two types - criminal and civil.

The principal piece of legislation concerning **criminal law** is the Health and Safety at Work Act 1974 (HSW Act). The Act has far reaching implications for visitor risk management. The essence of the Act is that employers have a duty to identify and manage risks 'so far as is reasonably practicable'. Although the main target of the Act is the safety of employees, it also requires an employer to conduct his/her undertaking in such a way as to ensure, so far as is reasonably practicable, the health and safety of persons who are not his/her employees. This includes members of the public.

Case law has established that the definition of an 'undertaking' is extremely wide and could easily encompass the ownership and /or management of property, including water spaces, by a navigation authority, as well as the activities which take place on it.

The term 'employer' is generally accepted as anyone who employs someone under a contract of employment and would include navigation authorities regardless of their constitutional status, size and resources. In short, there is no escaping or avoiding the implications of the HSW Act for any navigation authority.

The HSW Act gives the Secretary of State the power to make health and safety regulations. Both the Act and the regulations made under it are enforced by the Health and Safety Executive (HSE) and by local authorities. Certain accidents to members of the public are reportable to the enforcing authority under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) (see Section 6 for more details). If members of the public complain about the activities of an 'employer', HSE or a local authority have processes in place to follow up the complaint (which may involve a site investigation). Incident and complaint investigations are likely to focus on the way an organisation identifies and manages risk. Whilst it might be dangerous to generalise, inspectors do not automatically find an organisation at fault just because an accident has happened. Rather, they will be looking for evidence of effective safety management, whether the accident could have been foreseen, and whether the organisation did what was reasonably practicable to reduce the likelihood of it happening. The fact that an accident has happened tends to lead to questions about the adequacy of the organisation's health and safety systems and procedures.

Sanctions available to enforcing authorities include the issue of Improvement and Prohibition Notices. Magistrates' courts can impose fines to prescribed levels; higher courts can impose unlimited fines and in severe cases, sentences of imprisonment. More recently, the introduction of "Fee for Intervention" enables the HSE to levy charges at an hourly rate for their work in situations where there has been a 'material breach of health and safety law'.

The HSW Act also states that where an offence is committed with the “consent, connivance or neglect of any director, manager, secretary or other similar officer”, that person will be guilty of an offence along with the organisation. Where incidents result in fatalities, initial investigations will be undertaken by the police, who will investigate, in conjunction with the enforcing authority, whether there is any basis for manslaughter charges against individuals or corporate bodies. The introduction of the Corporate Manslaughter and Corporate Homicide Act 2007 (corporate homicide is the term used in Scotland) came into force in April 2008 and enables the prosecution of a corporate body where there has been an alleged ‘gross breach’ of a duty of care, punishable by an unlimited fine.

It is also important to stress that responsibilities under criminal law cannot be transferred to others (such as contractors) by contractual terms.

Examples of cases brought by HSE of relevance to navigation authorities:

HSE v Worsley Dry Docks Ltd: Manchester Crown Court, 21 September 2012

A Salford firm was fined £50,000 over the death of a canal boat owner at a dry dock on the Bridgewater Canal.
http://www.hse.gov.uk/press/2012/rnn-nw-worsleydrydocks.htm

An owner of a narrow boat sustained critical injuries after he slipped on a plank and fell head first to the concrete floor below at the Boatyard in Worsley on 26 May 2010. He died in hospital later that day.

The owner of the site, Worsley Dry Docks Ltd, was prosecuted by the Health and Safety Executive (HSE) at Manchester Crown Court in September 2012 after an investigation found the wooden board leading to his boat had not been secured.

The man and his wife had taken their narrow boat to the dry dock to carry out maintenance work to the hull while it was out of the water. He was attempting to cross from his boat to the side of the dock and as he stepped onto the plank (known as a Youngman board), which was both unsecured and had no edge protection, it began to move. He lost his balance and fell nearly two and a half metres to the floor of the dry dock.

A HSE investigation found that Worsley Dry Docks had failed to provide suitable access to users of the dry dock to allow them to move safely to and from their boats. The company has since ensured all of the planks at the dry dock have hand rails, and that they are properly secured before being used.

Worsley Dry Docks Ltd. pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc. Act 1974 and was fined £50,000 and ordered to pay over £15,000 in costs.

The investigating HSE inspector said:
"Having an unsecured board was a wholly inadequate way of accessing boats at the dry dock, given that boat owners regularly used it to walk above a concrete pit several metres below. If a secured gangplank with a handrail had been in place at the time he was using the dock then his life could have been saved."

The company has since discontinued any access to and work by boat owners on their own boats whilst in dock undergoing maintenance.

HSE v Tameside Metropolitan Borough Council and Clockwork Day Nursery Ltd.
Trafford Magistrates' Court 17 January 2008

A local authority and a day nursery were prosecuted following a serious accident to a child in a park
http://www.hse.gov.uk/press/2009/coinw01408.htm

Background
A four-year-old child received serious internal injuries after being swept down a water spillway and impaled on a tree branch.

A group of 20 children from Clockwork Day Nursery were taken on an outing to Stamford Park, Ashton-under-Lyne on 7 June 2006. The children, aged between four and 11, were taken to the park by four nursery staff, one of whom was a female worker who had not been cleared to work with children. One of the children had special needs and required one-to-one care. The children were left to play without supervision and ran out of sight of the staff. A number of the children wandered off into some bushes and came across a water spillway which channeled water from a nearby reservoir. The spillway was protected by a 0.6 metre wall on each side and some of the children stepped down into the waterway so as to cross to the other side. One of the children was attempting to cross the water, when he slipped on some algae and was swept 24 metres to the bottom of the spillway and became impaled on a branch at the bottom of the spillway, sustaining stomach injuries.

It emerged that some of the children ran back to inform the nursery staff about the accident but the staff didn't believe them and ignored their warning. A passer-by found the injured boy and carried him back to level ground before calling for an ambulance. The nursery staff only became aware that the boy was actually injured when the ambulance arrived.

Enforcement action

The investigating HSE inspector said that Tameside Metropolitan Borough Council (MBC), which managed the park, had an obligation to protect children from hazards. The council had been issued with an Improvement Notice after the accident, requiring fencing to be erected around the spillway to prevent children from gaining access.

Clockwork Day Nursery Ltd pleaded guilty at Trafford Magistrates' Court on 17 January 2008 to breaching Section 3(1) of the HSWA 1974 and Regulation 3(1) of the Management of Health and Safety at Work Regulations 1999. The company was fined a total of £21,000 and ordered to pay costs of nearly £7,000. The nursery appealed against the sentence but the decision was upheld in the Crown Court.

Tameside MBC pleaded guilty to breaches of the same legislation at the same hearing and was fined a total of £25,000 and ordered to pay over £23,500 costs.

HSE commented: "These cases are not about stopping children having fun. However, there is an obligation to protect vulnerable people from dangers. This was a serious incident, which resulted in a child receiving horrific abdominal injuries. It could have easily been avoided had simple and sensible precautions been taken by the nursery and the council. Tameside MBC failed to recognise the potential for danger and did not make a suitable assessment of risks to the public and, in particular, children, from the accessible and unprotected water channel. The nursery did not carry out a sufficient risk assessment for the outing and failed to ensure that the injured child was not put at risk. Supervision is critical and should reflect the needs of the party, the activities being carried out, the age and ability range of the children, and the risks of the location."

Fencing

The photographs were taken in February 2009 after the conclusion of the HSE prosecutions, showing the fencing erected by the local authority to comply with the Improvement Notice.

Comment

From the perspective of the landowner, the key lesson to be drawn is the need for an assessment of risks to users of the park. This should have identified that the park was regularly used by relatively vulnerable groups. It would also have dealt with the characteristics of the different parts of the park, and the easy transition that could be made from a typical urban park with gentle terrain, formal flower beds and surfaced paths, to a less developed wooded environment with natural path surfaces, steeper slopes and exposed rocks, created in Victorian times. It is relevant that the spillway is a man-made construction, not a natural feature, and whilst of historic interest, its historic significance is perhaps limited. The fencing is substantial and whilst intrusive in this more natural, wooded setting, this is necessary given the severity of the hazard and the close proximity to the urban park setting.

HSE v Birmingham City Council, Birmingham Crown Court, July 2002

Birmingham City Council was prosecuted by the Health and Safety Executive in July 2002, following the deaths of three people who were killed when the cars in which they were travelling were struck by a falling ash tree. The council had failed to put into place a proactive system to deal with tree maintenance, and did not have staff trained in such matters. The tree was diseased, and it was held that its condition and the danger it presented would have been obvious to anyone making a close inspection. The Council was fined £150,000 with £56,000 costs awarded.

Most of the legal cases encountered by navigation authorities are brought under **civil law**. These cases are generally brought on the basis that the defendant has failed to act reasonably in discharging a duty of care to the user. The foundation of most personal injury actions is in proving negligence under the common law, although a civil case can also be brought for breach of statutory duty that results in injury. An action for damages is brought in the civil courts. These claims require a lesser standard of proof than cases under criminal law. For a case to succeed the negligence must be shown on a 'balance of probabilities' rather than the more severe test of 'beyond reasonable doubt' which applies to criminal cases. To win an action and be awarded compensation the injured person must be able to demonstrate that they were owed a duty of care, and there was a breach of that duty leading to the injury.

There are no prescribed penalties in civil cases. A claimant who successfully proves that a defendant has breached his duty of care will be awarded damages. Courts generally use previous cases as a guideline for the correct level of damages but, generally speaking, the more severe the injury, the higher the level of damages. The legal costs associated with making and defending against claims can also be considerable.

Common law duties essentially derive from decisions made by judges over the years. Under common law you owe someone a duty of care if there is:

- sufficient proximity between you and the person injured, and it was
- reasonable to foresee that harm may result from your actions, and
- it is fair, just and reasonable to impose a duty of care on you

Proximity can be geographical, contractual, or through a care situation (for example between teacher and child). If you breach that duty of care, and foreseeable physical or psychological damage results, then you are liable to negligence. An employer may be held liable for the negligence of his employees (this is called vicarious liability).

The visitor must take reasonable care for his own safety. If he doesn't and comes to harm, then his 'contributory negligence' would lessen any claim against you. Note that children cannot be expected to appreciate dangers in the same way as adults. It is highly unlikely that contributory negligence could be attributed to the actions of a very young child. Adults, however, would be expected to exercise responsibility for children in their care.

You are not liable for risks that are willingly accepted by a visitor or trespasser. However, you need to show that the risk was, in fact, accepted. That a person proceeded beyond a warning sign cannot in itself be relied upon to signify that the person had accepted the risk. The actual risks accepted will be limited to those normally arising in the circumstances. Visitors might, for example, willingly accept the risks specifically arising from a sport or recreational activity in which they are participating. However, they are not accepting any additional risks that arise out of your negligence.

Darby v National Trust

Hardwick Hall is a National Trust property in Derbyshire. It includes a large country park, which is a popular attraction for the large urban population nearby. Within the park are two large lakes, and five small ponds. These ponds are roughly square in shape, approximately twenty metres across and, in places, over two metres deep. The ponds are used for licensed fishing.

In August 1997, a family were on a day out and the 45 year old father entered the water and was seen 'bobbing up and down' below the water to entertain his children. On one occasion he did not resurface. Despite the efforts of rescuers he died in hospital three days later.

After the accident, the widow began civil proceedings against the National Trust for compensation (there was no enforcement action taken by HSE). The case (heard in March 2000) concerned the Trust's duties under the Occupiers' Liability Act 1957 to warn against and to take steps to prevent swimming in the pond. The claimant received expert advice, claiming that the pond was unsuitable for swimming and that there should have been a strategy in place to prevent swimming. In the absence of such a strategy and suitable warnings, the judge decided that the accident was mainly attributable to the National Trust's failings and awarded substantial compensation.

The National Trust took the case to the Court of Appeal in January 2001. The Court overturned the original decision, adopting a common sense view that people should take proper responsibility for their own actions. The logical extension of the claimant's argument was that the entire coastline and all inland water sites would need 'no swimming' signs. The Court decided that apart from the water being deep and murky, there were no additional dangers involved in swimming in this pond. As a result, no warning sign was needed - it would not have told visitors anything they should not already have known. In reaching this decision, the Court developed the approach taken in Staples v West Dorset District Council (see below), in which it was decided that a landowner is not under a duty to warn visitors about risks that are obvious.

The judge stated:
"It cannot be the duty of the owner of every stretch of coastline to have notices warning of the dangers of swimming in the sea. If it were so, the coastline would be littered with notices in places other than those where there are known to be special dangers which are not obvious. The same would apply to all inland lakes and reservoirs. In my judgement there was no duty on the National Trust on the facts of this case to warn against swimming in this pond where the dangers of drowning were no other or greater than those which were quite obvious to any adult such as the unfortunate deceased. That, in my view, applies as much to the risk that a swimmer might get into difficulties from the temperature as to the risk that he might get into difficulties from mud or sludge on the bottom of the pond."

In September 2001 the claimants were refused leave to appeal to the House of Lords.

The Occupiers Liability Acts 1957 and 1984 (OLA) and the Occupiers Liability (Scotland) Act 1960 deal specifically with the duty of care owed by occupiers of premises to their visitors. An "occupier" for these purposes could be a navigation authority and the "premises" in question could be defined as "property" which many interpret as including water. The duty of care under OLA is owed to both lawful visitors and (to a lesser extent) trespassers. In the event of an accident the occupier will need to demonstrate that his actions were reasonable in the circumstances.

Trespassers cannot make a claim for loss or damage. They may, however be able to claim for personal injury. You have a duty of care under OLA 1984 towards trespassers if:

- you are aware of the danger or have reasonable grounds to believe that it exists, and
- you know that the trespasser is, or might be, in the vicinity of the danger, and
- the risk is one against which, in all the circumstances, you may reasonably be expected to offer the trespasser some protection. You are obliged to take such care as is reasonable in all the circumstances to see that the trespasser is not injured by the danger.

There are many pieces of OLA case law relevant to navigation authorities. Whilst it is difficult and sometimes dangerous to generalise, the main conclusions which can be drawn from these cases are:

- You should consider the particular needs of people invited onto your property (e.g. elderly or disabled).
- You should be able to demonstrate that your precautions are 'reasonable'.
- The historic nature of premises has a bearing on what is 'reasonable'.
- You are not necessarily required to warn of dangers when they are obvious (although the severity of the danger must be considered along with the risk of injury).
- Similarly, you don't necessarily have to fence hazards when the dangers are obvious.
- Children will be less careful than adults, and less able to understand signs. Parents and guardians have a responsibility for the children in their care.

One of the most significant civil cases in recent years, frequently cited in subsequent court cases, is Tomlinson v Congleton Borough Council. The case was finally decided in the House of Lords, giving it considerable authority. It is considered to be a landmark case since it determined that individuals must take responsibility for their own actions.

Tomlinson v Congleton Borough Council – case summary - Brereton Heath Country Park

An attractive lake bordered by sandy beaches forms the centrepiece to Brereton Heath Country Park in Cheshire. Families visit the park to play on the beach. It was common for people to swim in the lake, ignoring the Council's "no swimming" signs and the advice of park rangers.

Mr Tomlinson ran into the water up to his knees and plunged forward. He struck his head on the sandy bottom of the lake, breaking his neck, and was rendered tetraplegic.

The case examined the liability of the Council under OLA 1957 and 1984 in respect of dangers due to the state of the premises or things done or omitted to be done on them.

The judges found that there was nothing about the mere at Brereton Heath which made it any more dangerous than any other ordinary stretch of open water in England. There was nothing special about its configuration; there were no hidden dangers. It was shallow in some places and deep in others, but that is the nature of lakes. Nor was the council doing or permitting anything to be done which created a danger to persons who came to the lake. No power boats or jet skis threatened the safety of either lawful windsurfers or unlawful swimmers. It seems that Mr Tomlinson suffered his injury because he chose to indulge in an activity which had inherent dangers, not because the premises were in a dangerous state.

Lord Hoffmann observed: "The risk was that he might not execute his dive properly and so sustain injury. Likewise, a person who goes mountaineering incurs the risk that he might stumble or misjudge where to put his weight. In neither case can the risk be attributed to the state of the premises. Otherwise any premises can be said to be dangerous to someone who chooses to use them for some dangerous activity."

Even if the risk had been attributable to the state of the premises the question of what amounts to "such care as in all the circumstances of the case is reasonable" depends upon assessing, as in the case of common law negligence, not only the likelihood that someone may be injured and the seriousness of the injury which may occur, but also the social value of the activity which gives rise to the risk and the cost of preventative measures. These factors have to be balanced against each other.

It is necessary to take into account the social value of the activities which would have to be prohibited in order to reduce or eliminate the risk from swimming. "The majority of people who went to the beaches to sunbathe, paddle and play with their children were enjoying themselves in a way which gave them pleasure and caused no risk to themselves or anyone else. This must be something to be taken into account in deciding whether it was reasonable to expect the council to destroy the beaches."

There is also the question of whether the council should be entitled to allow people of full capacity to decide for themselves whether to take the risk. Mr Tomlinson was freely and voluntarily undertaking an activity which inherently involved some risk.

Lord Hoffmann's opinion was that "it will be extremely rare for an occupier of land to be under a duty to prevent people from taking risks which are inherent in the activities they freely choose to undertake upon the land. If people want to climb mountains, go hang-gliding or swim or dive in ponds or lakes, that is their affair. Of course the landowner may for his own reasons wish to prohibit such activities. He may think that they are a danger or inconvenience to himself or others. Or he may take a paternalist view and prefer people not to undertake risky activities on his land. He is entitled to impose such conditions, as the Council did by prohibiting swimming. But the law does not require him to do so."

"…there is an important question of freedom at stake. It is unjust that the harmless recreation of responsible parents and children with buckets and spades on the beaches should be prohibited in order to comply with what is thought to be a legal duty to safeguard irresponsible visitors against dangers which are perfectly obvious."

In the event of an accident, the occupier will need to demonstrate that his actions were reasonable in the circumstances. Occupiers have been found liable in various ways - for example, in failing to light stairs or for failing to clear an obstruction that created a tripping hazard.

An occupier may have some liability for an accident on adjacent premises. If the occupier is aware of a danger on adjoining land that is not readily apparent to a visitor, and if there is ready access from the occupier's land, the occupier may have a duty to prevent the visitor straying into danger.

You do not have to warn of dangers when it is reasonable to assume that they are obvious to the visitor. There have been a number of examples in case law, such as:

Staples v West Dorset District Council

A visitor to the Cobb, an historic harbour wall at Lyme Regis, slipped and fell off the wall, sustaining injury. The weather was fine but a strong wind and spray were affecting its surface. His original claim was upheld, the judge finding that the Council was at fault for failing to erect a warning sign to tell users of the particular danger of the surface being slippery. The Court of Appeal overturned this judgement, concluding that the risk of the wall being slippery when wet was so obvious that no duty existed. It also concluded that even if a warning sign had been in place it was unlikely that the claimant would have acted differently. A warning sign was therefore not necessary.

You do not always have to fence hazards, if they present an obvious danger:

John Malarkey Duff v East Dumbartonshire Council and others

A natural, physical feature of the land, the dangers of which are plain, does not require to be guarded by protective measures, despite being capable of causing danger to careless persons. It is reasonable to expect the visitor to be aware of sudden drops. "To hold that this embankment constitutes a concealed danger which ought

to have been fenced would in my view defy common sense. The logical extension of such a finding would be that every path along an embankment or cliff edge would require to be fenced in order to guard against a fall by a person going too near the edge and losing his footing".

You must consider the particular needs of people you invite onto your property. A council was found at fault when an elderly person was injured when he tripped on an uneven path leading to a council building. It was of particular importance that the path was used by many elderly people likely to be unsteadied and upset by variations in the path with potentially serious consequences. It was found that the pathway could easily and cheaply have been repaired by pointing and relaying.

You must be able to demonstrate that your precautions are reasonable in the circumstances. A visitor slipped and was injured on a sloping pathway at a school following a bad snowfall. The judge was entitled to take into account the subsequent installation of a handrail in concluding that the sloping pathway was a candidate for special treatment. He judged that even though the path had been cleared and gritted before the accident, this was insufficient, given the prevailing conditions at the time and the particular nature of the path in question.

You must be prepared for children to be less careful than adults. Furthermore a warning sign, however clear in itself, cannot warn a child if he/she is unable to read. In some circumstances, particularly in the case of a young child, the parent may hold the primary duty of care. Warning a visitor of dangers might be sufficient to absolve you from liability, but only if it was sufficient to enable the visitor to be reasonably safe.

The historic nature of the premises can be relevant:

Hunt v The Chapter of Ripon Cathedral

In June 2006, a visitor to Ripon Cathedral suffered an ankle injury when stepping in a depression on a step leading to the Crypt. The visitor took the Cathedral to court to claim for damages but the judge ruled in favour of the Cathedral, finding them not liable.

To protect visitors the Cathedral had taken the following precautions:

- a risk assessment of the area had been completed and found there was no significant danger;
- the area was well lit;
- a one-way system was in operation to guide visitors;
- signage was present to guide people along the one-way system.

The court found that:

- in view of the narrow width of the walkway, installing a hand rail was not necessary;
- no additional signage was required to warn about the danger of injury;
- heritage buildings like the Cathedral have uneven surfaces. It was only reasonable for the Cathedral to interfere with the fabric of the building if it posed a real danger;
- it was reasonable to assume that visitors would carefully place their feet when walking in a place of such antiquity.

Under section 2 of the Occupiers Liability Act 1957 owners of any building must take reasonable care to protect visitors. The court ruled that the Cathedral had fulfilled its responsibility in this respect and dismissed the case.

Appendix 2

Guiding principles for managing visitor safety in the countryside and on the waterways

The Visitor Safety in the Countryside Group (VSCG) was set up in May 1997. The original members came together with a shared vision of implementing sensible risk management for visitors to the countryside, since at the time there was little relevant safety guidance for landowners and land managers on this subject. The group met regularly to exchange information and best practice and to develop ideas - in particular, it looked at how to create safe access to the countryside and historic structures in ways that do not spoil the landscape and heritage or diminish the visitor experience.

One of the first tasks the group set itself was to create a set of guiding principles. The principles apply to individuals and groups visiting land, water, buildings and other structures. They are relevant to country parks, canals and rivers in urban areas as well as more open countryside. Visitors include people engaged in informal recreation as well as participants in various sports and activities. The principles are intended to provide a framework to guide individual managers and to help inform judgement when issues of visitor safety are being considered. They are grouped under five main headings – Fundamentals, Awareness, Partnership, Responsibility and Risk Control, but were not intended to cover employee safety or the work of contractors. The group wanted to emphasise the importance of conservation, access and personal enjoyment in the countryside, and the need to find a balance between safety and these wider objectives. There was also a balance to be achieved between personal responsibility and the responsibility of the landowner or manager. The full set of principles can be found at http://vscg.co.uk/guiding-principles/.

One of the most important principles stressed the importance of striking a balance between user self-reliance and management intervention. To illustrate this, a risk control matrix was devised, showing how, as the location becomes less developed and the terrain becomes more wild and remote, the need for management intervention decreases, whilst reliance on the skills and abilities of those using the countryside increases. The matrix is shown overleaf.

Risk control matrix for water environments

Zone and activity →	Natural waters/immersion water sports	Rural waterways/placid activities	Urban waterways	Visitor centres/museums/heavily developed sites
RISK CONTROL SPECTRUM	Increasing visitor self-reliance ←		Increasing management intervention →	
Level of visitor's skill and self-reliance	**Advanced**	**Moderate**	**Minor**	**Minimal**
Personal safety skills	Thorough knowledge of activity through personal experience and training, competent personal safety skills and self-reliance expected. Accepts responsibility for own safety.	Skills and knowledge of activity, personal safety and self-reliance important. Understands surroundings and takes some responsibility for own safety.	Understanding of the activity, personal responsibility and self-reliance encouraged but not expected. Some experience and knowledge of surroundings.	Previous experience of activity and sites not expected. Visitors expected to follow advice and act responsibly.
Level of support from navigation authority	**Minimal**	**Minor**	**Moderate**	**Advanced**
Water type/activities	Open water exposed to natural elements. Running water subject to severe flows/turbulence. Uses include wind surfing, canoeing and use of personal water craft. Could have steep banks with poor access for land users.	Considerable levels of unmanaged vegetation in and out of navigation. Rural towpaths with natural surface used by walkers, anglers and cyclists. Modest level of fitness desirable. Access facilities for the less able unlikely.	Managed water space, limited level of fitness expected. Well maintained, surfaced towpaths. Reasonable access for the less able.	Highly managed waters pace well lit and signed, possible provision of lifesaving equipment. Level access with no hidden dangers, accessible for all ages with full facilities for the less able.
Hazard management	Minimal management intervention	Minor intervention limited use of physical safety measures, few warning signs	Moderate management intervention, some physical measures and advisory signs expected	Advanced management intervention, physical safety measures provided with clear signs about hazards, and advance warning information. Managers provide for first time visitor staff presence likely

The original principles have been taken up subsequently and adapted by other organisations to suit their circumstances. In particular, the National Water Safety Forum has developed its own principles for water safety. The set of principles falls under five separate headings - Fundamentals, Partnership, Awareness, Competence and Communication. The principles can be found on the National Water Safety Forum web site at http://www.nationalwatersafety.org.uk/about/principles-noflash.asp, but are reproduced here.

National Water Safety Forum – Water Safety Principles

Fundamentals

No activity can be made completely risk-free

Risks imposed on non-participants and over which they have little or no awareness or control, can only be accepted if they are very low. *(The principle of the voluntary acceptance of risk - no nasty surprises)*

All the benefits of water-related activities will be taken into account when making the balanced judgement of whether risks are acceptable or further risk control measures are necessary. *(These benefits will include amongst others health and fitness, access to the countryside and coast, social inclusion, economic development, disability access and sporting objectives.)*

As above, all the dis-benefits and costs of water-related activity will similarly be taken into account. *(These include provision of rescue services, access restrictions, transfer to riskier activities (e.g. swimming in docks when pools close).*

As far as possible, avoid restricting access to water spaces or facilities

Look ahead by assessing the risks that can be foreseen

Learn from the past. *(Records of accidents, near misses and ill-health, together with reports from the participants inform present day decision-making).*

As far as possible, avoid additional regulatory controls. *(These should only be considered where accident rates are high, multiple casualties occur, children or elderly or disabled persons are involved, the risk is unclear to participants or affects non-participants (i.e. an involuntary risk).*

Responsibility

It is important to strike a balance between the self-reliance of the individual participant and management interventions. *(The greater the competence and risk-awareness of the participant, the greater the scope for the managing organisations not to intervene. Many benefits of water-based activities can be realised by encouraging self-reliance, not dependency on a managing organisation).*

Everyone involved in a water-related activity has some responsibility for ensuring their own safety. *(Includes participants complying with best practice as set down by sports governing bodies, and ensuring they are not impaired by drink or drugs).*

Recognise that statutory bodies and organisations with management responsibilities may have only limited powers to require or enforce.

Avoid as far as possible the use of risk controls which discourage people from participating in the organisation or management of an activity. *(Many activities rely on the active support of non-participants, often given voluntarily. Excessive or insensitively applied risk controls can discourage this support and even threaten the continuance of the activity).*

Recognise that children's risk perception skills will not be fully developed. *(This must be taken into account in the design of facilities and activities, and by parents/guardians in the supervision of children).*

Partnership

Recognise that people taking part in similar activities will accept different levels of risk

(Take this into account when planning facilities or activities. Higher levels of participant competence may offset the need for other types of risk control).

Recognise that risk control measures for one participant group may create risks to others. *(For example, fences erected to prevent people falling into water may impede rescues of people from the water).*

Work with groups representative of participants to promote understanding and resolve conflict

Collect incident data in partnership with others wherever possible. *(This will increase greatly the value of the collected data).*

Awareness

Ensuring that participants are aware of and understand potential hazards and risks is the key element in ensuring that risks are undertaken voluntarily. *(There are no nasty surprises awaiting participants).*

Information and education of participants about the nature and extent of hazards, the risk control measures in place, and the precautions, which the participants should take, are crucial elements of risk control

Wherever possible, integrate safety information with other information provided to the public. *(These could include leaflets, interpretation boards and websites).*

Competence

Recognise that some participants over-estimate their skills and abilities to a large degree. *(For example, young men and swimming).*

Recognise that participants will have a range of abilities to recognise any given hazard. Some will over-estimate while others will under-estimate and sometimes fail to recognise a hazard exists

Where competence levels are judged to be inadequate, the NWSF will encourage training to improve competence.

Communication

Managing organisations, sports governing bodies and user representative groups need to effectively communicate the results of risk assessments and risk awareness material to the participants

When communicating to actual or potential participants, take account of the language, literacy and cultural needs of the target audience

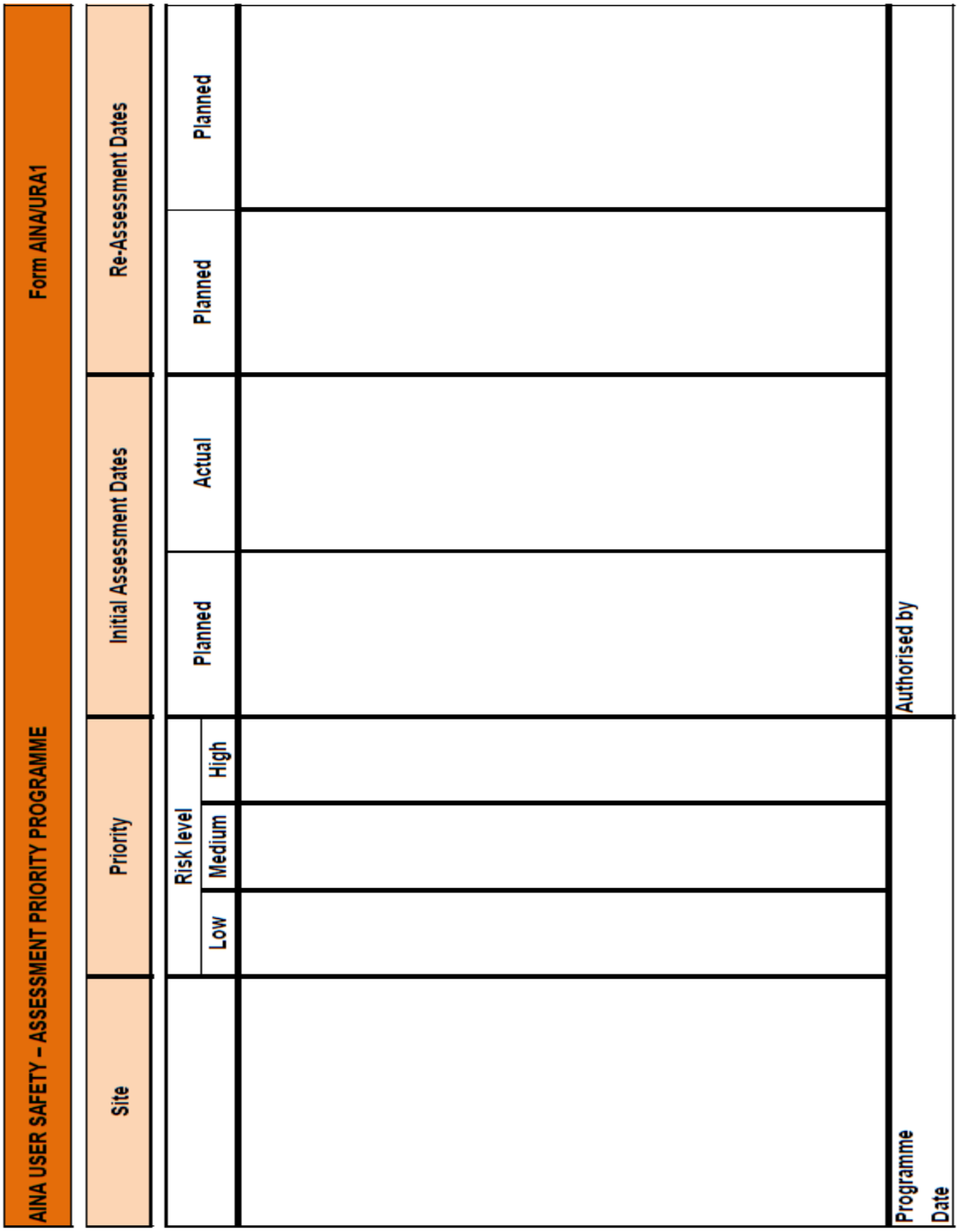
Footnote

For many years, navigation authorities have also followed the guidance contained in the RoSPA publication – “Safety at Inland Water Sites – Operational Guidelines” (1999). This booklet is undergoing revision (2013). Since the first edition of the guidance, much has changed in the approach to managing inland water sites and the expectations of users. Events such as open water swimming and triathlons have grown in popularity. Many open water spaces have been transformed from primarily “working docks” environments to residential, leisure and retail facilities, and are often a tourist attraction in their own right. Civil judgments such as *Darby v National Trust* and *Tomlinson v Congleton* have marked a move away from overly paternalistic decisions and demonstrated that the courts now place greater emphasis on personal responsibility.

Appendix 3

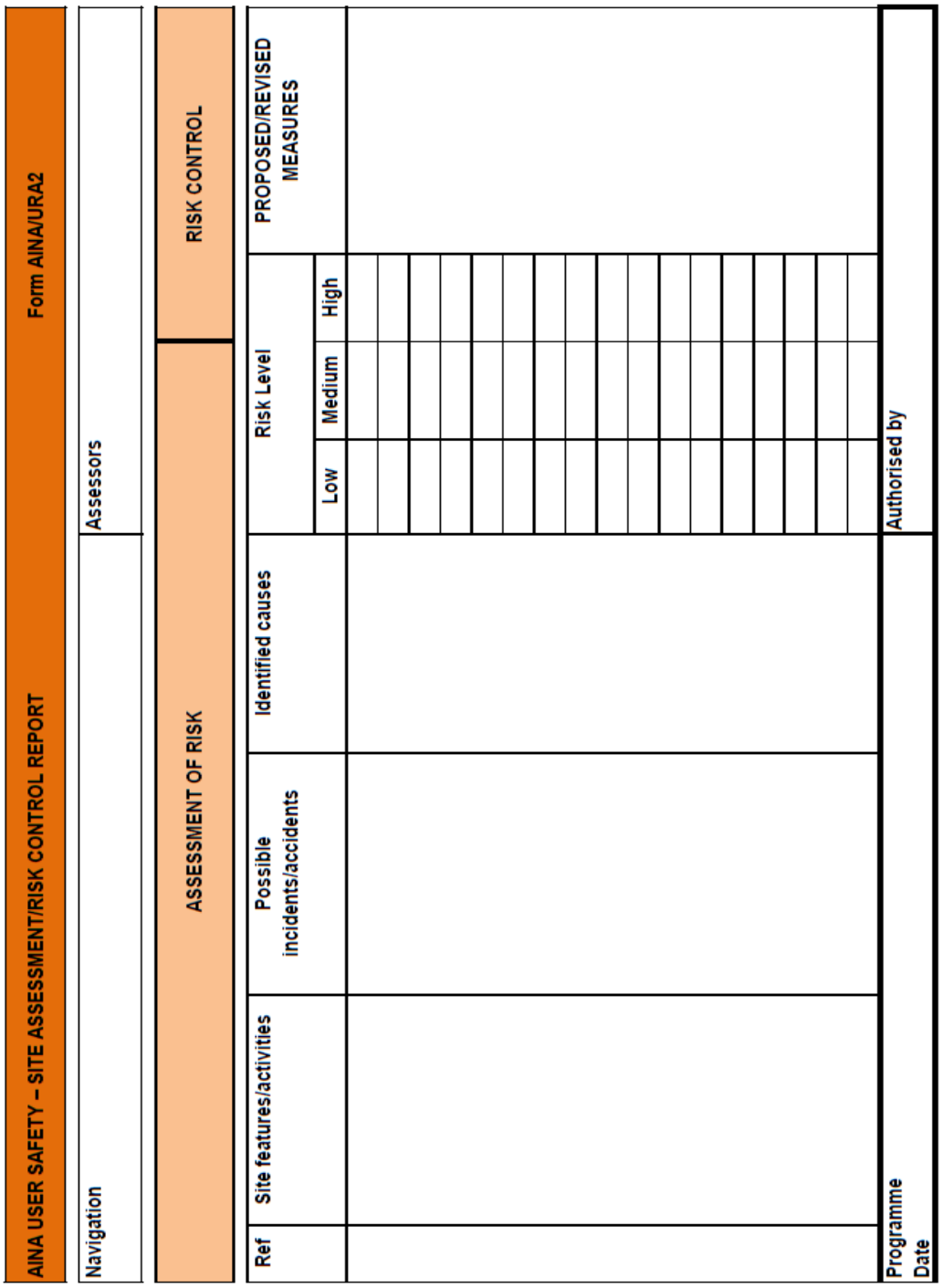
Sample visitor safety forms

3.1 Assessment priority programme



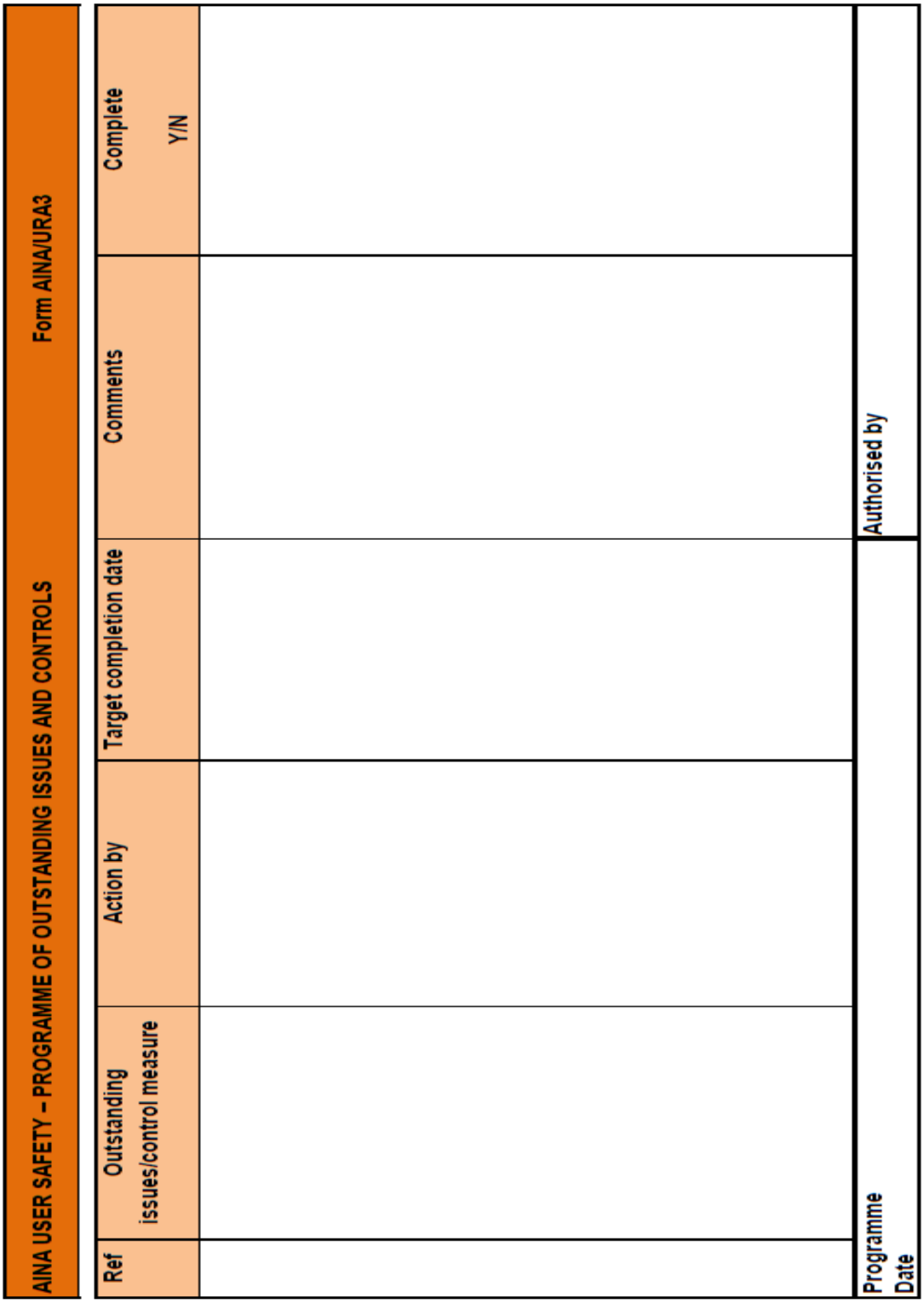
AINA USER SAFETY – ASSESSMENT PRIORITY PROGRAMME										Form AINA/URA1
Site	Priority			Initial Assessment Dates		Re-Assessment Dates				
	Risk level			Planned	Actual	Planned	Planned			
	Low	Medium	High							
									Authorised by	
									Programme Date	

3.2 Site assessment – risk control



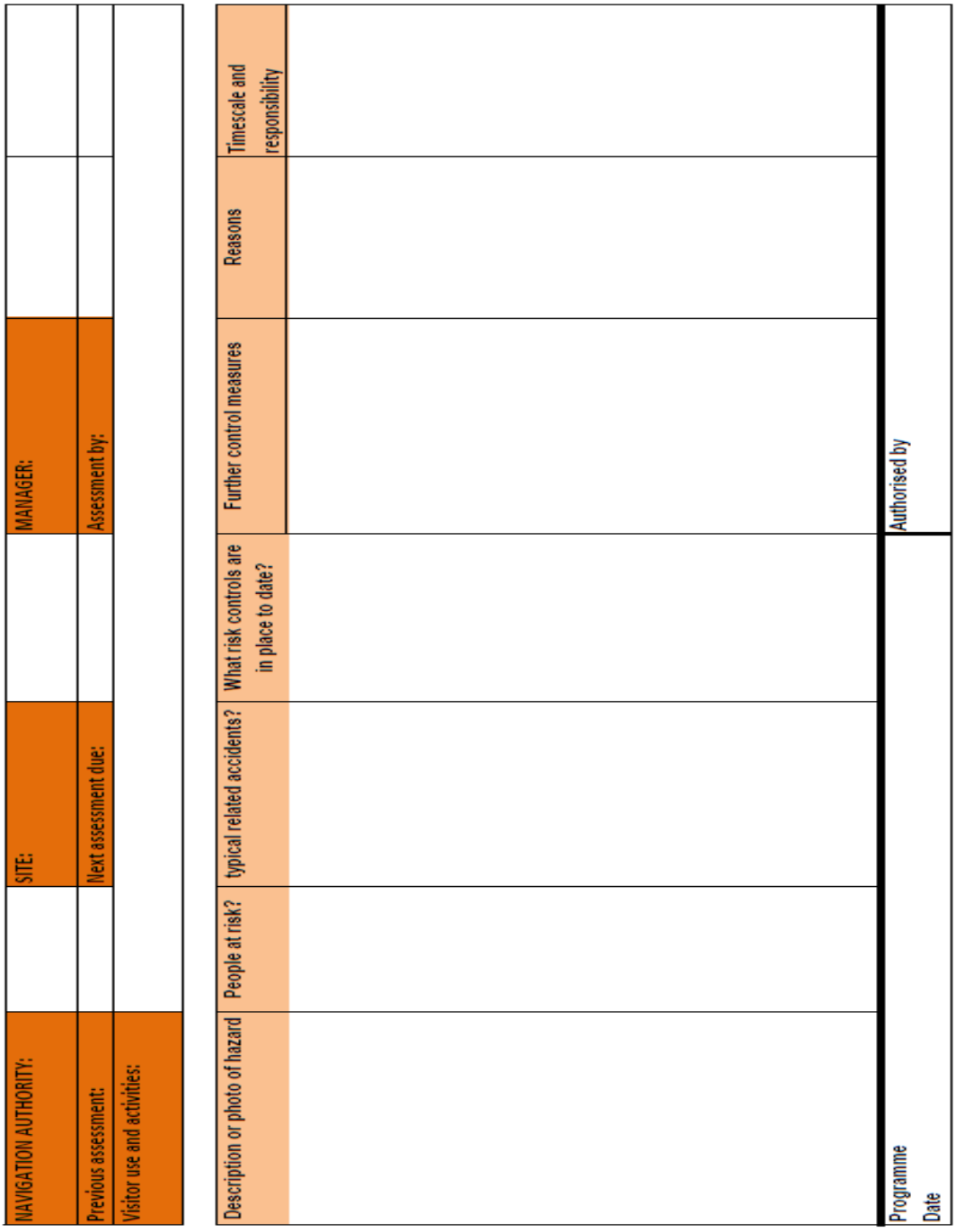
AINA USER SAFETY – SITE ASSESSMENT/RISK CONTROL REPORT									Form AINA/URA2
Navigation								Assessors	
		ASSESSMENT OF RISK						RISK CONTROL	
Ref	Site features/activities	Possible incidents/accidents	Identified causes	Risk Level			PROPOSED/REVISED MEASURES		
				Low	Medium	High			
Programme Date							Authorised by		

3.3 Programme of outstanding issues and controls



AINA USER SAFETY – PROGRAMME OF OUTSTANDING ISSUES AND CONTROLS					Form AINA/URA3
Ref	Outstanding issues/control measure	Action by	Target completion date	Comments	Complete Y/N
Programme Date				Authorised by	

3.4 Site risk assessment/risk control report



NAVIGATION AUTHORITY:		SITE:		MANAGER:			
Previous assessment:		Next assessment due:		Assessment by:			
Visitor use and activities:							

Description or photo of hazard	People at risk?	typical related accidents?	What risk controls are in place to date?	Further control measures	Reasons	Timescale and responsibility
Programme Date				Authorised by		

APPENDIX 4

AINA incident report form

Incident number

Core information
(needed for analysis)

Additional information
(nice to have)

What happened
(details of incident)

Source of information
(eye witness, person involved, press cutting)

Name and contact address

Where did it happen
(location, canal, river, lock weir etc)

When did it happen?
(date and time)

Has the incident been reported under RIDDOR?
(Yes/No/Don't know)

Has the incident investigation been completed?
(Yes/No/Don't know)

How did it happen?
(details of incident)

Did the person need hospital treatment?
(Yes/No/Don't know)

Date reported

Who was involved?

Name of injured person

Sex m/f **Age**

Relationship to organisation (eg employee/member of the public)

Name of reporting organisation

Name of person reporting and position in organisation

Address

Telephone number

APPENDIX 5

Incident investigation report form

Incident number	**Location**	**Report Number**
Details of injury/damage		
Events leading up to the incident		
Description of the incident		
What were the causes		
What can we do to prevent similar incidents		**Action Dates**
Name and signature of investigator		**Name and signature of line manager**