

Case Study Narrative

From Lyme Bay to Licensing

Past, present and future - the development of current regulation of outdoor adventure activities

<http://www.aals.org.uk/lymebay01.html>

The deaths of the four teenagers in the Lyme Bay canoeing tragedy in March 1993 will be remembered for a very long time by many people, not only family and friends, but also those involved in the outdoor activity community.

2 The canoeing tragedy itself was the result of a series of errors and circumstances, which the Devon County Council report states "quite simply, should not have happened." This report goes on to say that "the immediate cause of the tragedy was, however, the lamentable failure of the St Alban's Centre to organise and supervise the canoeing activity, to employ suitable staff and to have prepared and operated sensible and pre-determined procedures when difficulties arose." The successful prosecution of the parent company, OLL and the managing director, Peter Kite, was based around these issues.

3 The canoeing party set out from the Cob in Lyme Regis at about 10 a.m. on March 22nd 1993. The party of 8 pupils and their teacher were accompanied by two instructors from the St Alban's Centre. The intention of the trip was to cross to Charmouth and return to Lyme Regis by lunchtime. Almost as soon as the trip got underway, the teacher experienced difficulties, and whilst one instructor attended to him, the other instructor rafted the pupils together. The raft rapidly drifted away from the teacher and instructor, and lost sight of them. The pupils were wearing life jackets, the instructors bouyancy aids. No flares were carried, and the pupils did not have spray decks.

4 As the raft of kayaks drifted away from the coast, the wave height increased, and gradually, one by one, the kayaks were swamped until all nine individuals were in the water. Although the group had been due back for lunch at 12 noon, the emergency services were not asked to help until 15:30. The teacher and one instructor had remained in their kayaks, and were rescued by the inshore lifeboat at 17:31. The rest of the group were picked up by rescue helicopter between 17:40 and 18:40.

5 The events that surrounded and led to the loss of these four young people re-invigorated the campaign to better regulate the safety of outdoor activity providers, particularly those providing activities for school children. In addition, an investigation and review of coast guard procedures were undertaken, as the trial judge considered that the actions taken by HM coastguard on the day in question demonstrated "oversight" with regard to the search and rescue operation.