

activity was considered by Southway's Senior Management Team (SMT) in June 1992 when they had hoped that the entire first year sixth form (approx 70) would join the activity week - in the event only 23 did so.

- 7 John Ellis visited the St Albans Centre over a weekend in September 1992. It seemed a professional centre and the facilities appeared ideal. The location was appropriate since it allowed the students to be a reasonable distance from Plymouth. He felt that the Centre provided good basic accommodation with fairly good food at a reasonable price. He had Ray Baish's "recommendation" and he had access to ALL material about the Centre which amongst other things included specific reference to safety and supervision.
- 8 John Ellis was to be Group Leader during the visit. Mr Norman Pointer, another teacher at Southway, would join him for the first and second days. Ray Baish was to take over from Norman Pointer on Monday evening. Other staff would join in rotation over the next following days.
- 9 John Ellis reported on his preview visit to the Southway SMT. This comprised, at that time, Mrs June Mowforth (Senior Deputy Head confirmed as Acting Head during Autumn Term 1992), Mr Keith Diffey, Deputy Head, Norman Pointer and John Ellis. He was positive about the Centre.
- 10 Although there is no formal minute of discussion by the Southway Governors of the proposed activity week senior management at Southway have confirmed that Governors had been made aware of it.
- 11 The County Council as Local Education Authority has issued Guidance and Regulations for off-site activities in a document entitled "Safety in Outdoor Education" (Appendix C). Every school has at least one copy. Southway is no exception. This document is updated from time to time, the current edition dating from 1990. It is one of many LEA and DFE documents received in schools. The Devon document contains more detailed requirements than that issued by the DFE and in many respects parallels similar documents issued by other education authorities.
- 12 John Ellis has confirmed that he has seen, read and has a copy of the Guidance; he has also confirmed that he did not specifically use the document in planning the visit to Lyme Regis. Nor did June Mowforth.
- 13 There is a separate Southway staff handbook, of which all staff have a copy. It refers obliquely to the document 'Safety in Outdoor Education' and provides limited procedural guidance on educational visits.
- 14 Southway does not have any member of staff formally designated to co-ordinate or oversee all off-site activities. June Mowforth took responsibility to check that internal forms (Appendix 1) were

notes met school
comparable
checked

for
Guides

completed and any appropriate questions eg financial points were answered.

15 Southway records show

- (a) Several different brochures from ALL. Some refer to canoeing on the River Axe, others to the sea and the River Axe. All stress the qualifications of centre staff and are written in terms designed to inspire confidence in the centre's abilities and expertise.
- (b) Summer 1992 - a provisional booking for 22-26 March 1993.
- (c) 4 November 1992 - letter to parents enclosing leaflet giving "a few details" (Appendix 2)
- (d) 16 December 1992 - booking confirmation for 23 students. Date revised to 21-25 March. Surprisingly, ages of pupils on the form signed by John Ellis were incorrect in a number of cases. 7
- (e) 2 February 1993 - letter to parents seeking approval to attendance of son/daughter on the course. List of "kit required and activities anticipated" (Appendix 3).

16 The week of activities was not intended by staff nor understood by parents as designed for students to become proficient in any particular sport or endeavour. The teachers attending did not profess, nor were they understood by parents, to have particular proficiencies in the sports and endeavours likely to be encountered. They relied on the expertise advertised by the Centre - parents likewise. But at all times the teachers were in loco parentis to the students.

17 The LEA Guidelines Document provides a "Checklist For the Use of Commercial, Charitable and Private Facilities" (Appendix C, page 15) Because Southway did not operate to the Guidelines Document there is no evidence that staff worked through the checklist.

18 The critical questions on the checklist so far as this tragedy is concerned are related to a learning progression (Question 1), equipment (Question 3), staff experience and competence (Question 4, 5), guidelines and policies (of the centre) for each activity (Question 14), procedures for dealing with accidents (Question 15). Comprehensive questioning and open and honest answering of these questions between users of the Centre and Centre management might have avoided this tragedy. ?

19 Taking the relevant questions seriatim

(a) Question 1

- 1. "Can a course of activities be negotiated and designed to give a proper learning progression throughout the programme?"

It appears there was no detailed discussion concerning the previous experience of the students either prior to the visit or on the Sunday afternoon. One of the instructors did ask informally about the canoeing group's previous use of canoes.

For novice canoeists to take part in an inshore canoe expedition of this proposed length based only on their swimming pool experience does not indicate an appropriate learning progression. However, there was apparently no discussion on this point between visiting staff, students or instructors.

(b) Question 3

3. "Is equipment and resource provision suited to the task, adequately maintained and in accordance with current good practice?"

See para 16
Teachers unfamiliar with the activity in question are totally dependent on the purported expertise of the provider. Had Southway teachers asked this question and received an assurance they would not have been in a position to query such assurance. Equipment and resource provision on the day was inadequate for the group in question given the task they were set.

(c) Question 4 and 5

4. "Do the staff with whom you will work have a level of experience and competence which is at least equivalent to that you would expect of DCC staff for each specified activity?"
5. "Do the staff have the experience, competence and professionalism to work with the age and ability of the group members you have in mind?"

Previous experience or Devon County Council qualifications in outdoor land based activities of Ray Baish or John Ellis may have led them to question the experience and competence of the Centre instructional staff. This did not occur. However, only by providing the complete Guidelines Document to a centre and requiring formal confirmation that each member of staff to be deployed to each activity has reached the competence referred to in the Document can a school satisfy itself on the reply to this question.

Centre staff instructing the Southway group had neither sufficient expertise nor competence within the requirements of the Guidelines Document to take the particular group on to the sea in order to canoe to Charmouth.

(d) Question 14

14. "Are there stated guidelines and policies for each activity and do these conform to those listed within Safety in Outdoor Education (DES and DCC)?"

We are unable to answer this question; what we can say is that the ALL brochure contains an assurance relied upon by Southway which, in the event, proved totally unreliable.

(e) Question 15

15. "Does the provider have procedures for dealing with accidents and the administration of first aid?"

There was a lack of any pre-planned and co-ordinated response to the disappearance of the Southway group.

- 20 The Guidance Document makes clear at para 2.13 that "It is not possible for the County Council to approve each commercial, charitable or private facility on a regular and systematic basis" - hence the checklist. The checklist is of value, albeit limited first by the need for comprehensive questioning and open and honest answers as referred to above and second by the fact that this is a moving target. Questions raised for example as to competence of staff in autumn 1992 could not be answered so far as March 1993 staff were concerned since they had not been appointed. *should be*

- 21 The County Council had not inspected the St Albans Centre; post-tragedy research has confirmed that other Devon schools used it in 1992 but no specific criticisms of activity work in terms of safety were raised, criticisms being related to accommodation and food. The County Council has reduced its supervisory role over schools first in consequence of Local Management in Schools which has led to nearly 90% of education schools' funding being devolved into Devon's schools and second in response to budget reductions generally. Heads and Governors are responsible for decisions as to which centres to use. There is no requirement to involve the County Council as LEA except where hazardous activities take place outside the four SW counties, any visit abroad or where there is a concern as to safe practice. *any* *transferred*

- 22 The St Albans centre is "accredited" by British Activity Holidays Association. They accredited the centre in 1992.

It is known that on that occasion they did not examine any sea canoeing activity, confining their work to other land based and pool activities.

- 23 There is no regulatory body for activity centres, public or private. It became clear within a very short time of this tragedy that persons who had worked in 1992 at this particular centre had had real concerns about its competences and had reported to the centre's top management at ALL HQ. Had there been a regulatory body those concerns could have been reported to it for appropriate action. In that event this tragedy might not have happened.

- 24 The West Dorset District Council gave authority to the Centre in September 1992, expiring 31 March 1993, to enable canoe lessons during inclement weather to take place in the area known as the Victoria Pool (see map at Appendix 7(a)). Conditions applicable to that use are shown at Appendix 4. On 22 March 1993, the Southway group canoed in waters away from the Victoria Pool. *was* *the* *area*

- 25 As indicated at paragraph 3.2 and 3.3 above senior staff at Southway worked less to the Guidelines Document than to the pages in the school's Staff Handbook. These pages (Appendix 5) refer to "LEA regulations/guidelines" in the context of supervision and in the context of insurance arrangements require that parents be informed in writing of the responsibilities of the LEA.
- 26 It would not appear that senior staff at the school followed the Staff Handbook procedures to the letter. The procedures stress the importance of meeting parents - there was no meeting; they require detailed written information to be supplied to parents - the information in this case was patchy; they refer to [the need for] "a signed letter of indemnity [which] would serve to indicate that the parents are aware of the risks involved... where the visit includes potentially hazardous activities eg. climbing or canoeing". Whilst sending a letter might, in terms of a purported indemnity, be inappropriate nonetheless the school did not overtly raise with parents the fact that some activities might be hazardous. Against all of this, however, it needs to be borne in mind that Southway covers the entire 11-18 age range. The procedures would be followed comprehensively for those at the younger end of the age range but in a more limited way for a party of young adults comprising students recognised by Southway's senior management as some of their brightest and most mature.
- 27 Whilst the liaison with parents was less than that required by the Staff Handbook it is doubtful that any parents would have withdrawn their children from this activity week had all procedures been followed to the letter. They placed their confidence in staff; both staff and parents believed that they could rely on the expertise of the centre.

THE ACTIVITIES WEEK

- 28 On Sunday, 21 March 1993, twenty-three students and two teachers from Southway School arrived at the St Albans Centre.
- 29 The party having split into three groups after arrival on the Sunday undertook amongst other activities both dry land paddle training and capsized drill in the Centre's swimming pool. Capsized drill did not include the practice of techniques of re-entering a canoe from the water. The only member of the party who did not participate was John Ellis since he was taking video camera shots of activities. All were either novices or had very limited experience in the techniques required to handle a canoe and there appears to have been little attempt by Centre staff to identify their experience.
- 30 On Monday, 22 March 1993, the party divided into three (different) groups. A group comprising eight pupils, one teacher and two instructors went to the harbour at Lyme Regis for the purposes of sea canoeing. Details of this group are in Appendix 6.

31 At Appendix 7 are the following maps:

- (a) Harbour at Lyme Regis [OS Map (Scale 1:10000)]
- (b) Extract Marine Chart - Lyme Regis to West Bay
- (c) OS Map (Scale 1:25000) Lyme Regis to West Bay

The group had arrived at the harbour by 10am. The group entered the sea in the harbour to the East of the Cob Wall and by the lifeboat slip. [Point marked 'x' on the plan - Appendix 7(a)].

32 Extracts from reports from the Meteorological Office applicable to the Lyme Bay area are at Appendix 8. These were publicly available. The conditions recorded as applying at 10.30am by the Harbourmaster were:-

Winds NW 3-4
Sea Slight to Moderate
Visibility Good

To the West of the harbour, where a Dorset LEA Activities Centre is located, we had been told the wind at the time was WNW and the sea state was choppy.

33 The two other groups were involved in off-Centre activities that morning. John Ellis travelled with one group to Dartmoor. The third group, like the first, went to Lyme Regis harbour and embarked in dinghies. They spent part of the morning west of the harbour. They did not see the party of canoeists on the water; they came ashore early and returned to the Centre. The reason for the early return was that conditions were too rough. A safety boat under the control of a Centre employee operated with the dinghy group.

34 The more experienced of the two instructors with the canoeists - Mr Anthony Mann - apparently held a BCU (British Canoe Union - see Appendix 9 Letter to Times 27 March 1993 as to status of this body) qualification - 1 Star. The junior instructor - Miss Karen Gardner - also apparently held a BCU qualification again 1 Star. Details of the BCU Test and Awards Structure are at Appendix 10.

It is known that both of the instructors took part in canoe instruction under the invigilation of Mr Steven Gynes over a two-day period not more than fourteen days before the incident in question. Steven Gynes is BCU qualified to level Senior Instructor (Inland) and Trainee Senior Instructor (Sea) for the purpose of teaching and was hired in by the Centre to help train Centre staff. It appears to have been the intention that Steven Gynes would undertake further work with Centre staff over the coming weeks.

35 Anthony Mann, Karen Gardner and Norman Pointer - the Southway teacher with the canoeing group - embarked in Lazer II Three Fifty canoes while the eight pupils embarked in Mirage Scout canoes. None of these canoes was fitted with deck lines; none of the canoes had supplementary buoyancy. All canoeists were wearing wetsuits, though these had, it appears, only been supplied at the specific request of the students, in particular as a result of concern for Claire Langley

who suffered from rheumatism; the instructors alone were wearing cagoules; the instructors alone were using spray decks (which seal the cockpit area of the canoe to the body of the canoeist); the instructors were equipped with buoyancy aids whilst the rest wore lifejackets; the instructors had whistles - some of the others had whistles; Anthony Mann had a first aid kit and a tow line.

- 36 Before describing what happened to the canoeists, it is appropriate to comment on paragraphs 34 and 35 above in terms of the qualifications and equipment for sea canoeing as referred to in "Canoeing Handbook - Official Handbook of the British Canoe Union" extracts from which are reprinted here by kind permission of the author and publishers (see Appendix 11).
- 37 (a) Neither instructor had an adequate level of teaching award for this type of activity.
(b) In consequence, recommended ratio of "competent canoeists" to students was not met.
(c) Flares were not carried.
(d) Buoyancy of canoes was not supplemented as recommended.
(e) Only the two instructors had spray decks.
(f) Student canoeists were inadequately clothed.
(g) Instructors being not appropriately qualified or experienced an escort boat was a necessity.
- 38 As already mentioned the teacher, and as much a novice canoeist as the students, with the group was Norman Pointer. He was embarked, like the instructors, in a Lazer II Three Fifty canoe. This is lighter and shorter and of a lower volume than the canoes of the rest of the party. For a novice it was an inappropriate canoe in which to go to sea. It is less stable than the canoes which were used by the students.
- 39 The group had left the area adjacent to Lyme Regis harbour by approximately 10.30am. The instructors had decided that the group should head for Charmouth. The distance to Charmouth is approximately 3km. The group was aiming for a white building [a cafe/shop] which was visible to them at the outset and was, apparently, told it would take 45 minutes to get there and an hour to get back.
- 40 Very soon after setting off it appears that one of the students, Simon Dunne, capsized his canoe. The water was shallow enough for him to stand in. With assistance from Anthony Mann he got back in and rejoined the group. No advice appears to have been given as to how the group was to organise itself eg: line ahead, line abreast etc.
- 41 Almost immediately thereafter Norman Pointer capsized; with the assistance of Anthony Mann he got back in; he again capsized; again he got back in; the rest of the group tried to hold position so that Norman Pointer and Anthony Mann could rejoin them; Anthony Mann attached a line to Norman Pointer's canoe in order to tow him to the group but still Norman Pointer capsized; the effort of constantly climbing back into his canoe was seriously debilitating for Norman Pointer; he was sick in the water; he recalls that whilst the rest of

the group was still in sight he suggested that he and Anthony Mann return to shore as he felt he was a hindrance to the group; Anthony Mann appears to have thought it important to remain as a group and therefore directed his efforts to keeping Norman Pointer afloat; perhaps so that they would not become separated the rest of the group 'rafted up' with the exception of Karen Gardner; in the event Norman Pointer and Anthony Mann were unable to rejoin the group which eventually disappeared out of sight.

- 42 Because the canoes in the raft were not fitted with deck lines nor had any other lines available they could not be tied together. To stay together members of the group had to cling on to adjoining canoes. Because the students did not have spray decks sea water started to fill the cockpits of the canoes - particularly those on the raft's outer edges. Initially, the outer canoes were paddled by two of the girls. Fairly soon the two boys in the group moved their canoes to the outer edges of the raft. Karen Gardner joined the raft in the middle.
- 43 Before too long, the canoes on the outer edge of the raft filled with water, capsized and were abandoned. Although the two canoes in all probability did not capsize simultaneously, it is certain that the two boys in the group were the first to be in the water. They then laid across the remaining canoes, one to the front and one to the rear. For greater stability paddles were placed across the canoes. This was a technically appropriate decision.
- 44 However, with the additional weight of the two boys the remaining canoes would have sunk lower in the water. The outer canoes in the raft began to take an increasing amount of water. Canoeists in the outer boats moreover were attempting to paddle indian style; the physical demands were increasingly severe.
- 45 One by one canoes filled with water, capsized and were abandoned until eventually just one canoe, paddled by Samantha Stansbie, remained upright. Eight canoeists attempted to cling on to it. With no deck lines they could only hope to cling on to a slippery superstructure - an impossible task as they grew increasingly colder and wearier. They decided to capsize Samantha's canoe with a view to climbing on to the upturned boat and attempting to paddle in to land. The attempt failed. Not all were able to climb on. The canoe went round in circles. It was abandoned.
- 46 It is unclear as to when the eight students and Karen Gardner first became detached from Norman Pointer and Anthony Mann. It may have been as early as 11am. It is unclear when the first canoe was abandoned. It was almost certainly not too long into the incident since the first sighting of a capsized canoe from the group is fixed at 1.5 miles off-shore and 1.5 miles due East of Lyme harbour (see 5.1 below). This was some distance from the area where the remaining canoes were located (see 60 below).
- 47 In rafting up, the canoeists achieved the objective of keeping the group together; the disadvantage to rafting up is that there is more

surface area for a wind to take hold of. As the met reports foretold (see Appendix 8) observers have confirmed that in the late morning the wind shifted and strengthened slightly so that it was blowing offshore. So the raft, albeit decreasing in size, was driven further from the shore. At the same time further inshore Anthony Mann was struggling to keep Norman Pointer afloat; at some stage Norman Pointer lost his paddle; for Anthony Mann to have left Norman Pointer would, in all probability, have resulted in early capsizing for him - so that even if Anthony Mann had the ability to paddle in to shore against the wind he would have been concerned for the immediate safety of his charge.

- 48 Nine canoes capsized during the course of the day; eight were subsequently found within some proximity of most of the group. When a canoe capsizes it floats, often on its side, immediately below the surface of the water. The canoes were coloured red; they were, however, virtually invisible to other shipping - indeed the crew of the lifeboat which was directed to pick them up by a helicopter virtually ran them over before spotting them.
- 49 Nine canoeists were in the water; eight students were wearing yellow lifejackets. Upon examination after retrieval from the water it was clear that with the exception of one lifejacket which had a small amount of air in it, none had been inflated. Each lifejacket has 6KG buoyancy without inflation; inflation is achieved by blowing into a mouthpiece; inflation is the recommended step to prevent drowning; it pushes the head back out of the water; it cannot prevent hypothermia; it may reduce a person's ability to swim.
- 50 No canoeist wore a helmet; in consequence they were almost certainly less visible than the capsized canoes from above. From shore, they would be virtually impossible to spot. Moreover, wearing of a helmet assists in reducing loss of body heat through the head.
- 51 At 1443hrs the fishing vessel Spanish Eyes found a capsized canoe in the water [see Map(b) at Appendix 7 for location] and radioed the information to HM Coastguard at Weymouth/Portland. It is said by HM Coastguard to be not unusual for canoes or other boats to be found at sea. Without further information, it is not a cause for immediate concern. At the time, the wind was reported as NW3, the sea moderate and visibility good. The skipper looked around in the area; other boats in the area started looking out; the Coastguard started a general 'phone around for information about potential missing canoeists. This was not - nor could reasonably be expected to be - a formal search.
- 52 At 1458hrs the Coastguard and the Harbourmaster at Lyme Regis, Lt Cdr Goslin, were in contact with each other. The Harbourmaster reported the possibility of canoeists from the St Alban's Centre being overdue and/or missing. The Harbourmaster was aware that Joe Stoddart, St Alban's Centre Manager, was on the lookout for some canoeists and at that time Joe Stoddart is believed to have gone by vehicle to Charmouth to check whether they had come ashore.
- 53 At 1507hrs the Lyme Regis Harbourmaster and Joe Stoddart (who was

then with him, having returned from Charmouth) advised the Coastguard that ten (sic) canoeists were overdue on a trip from Lyme Regis to Charmouth comprising two instructors, one teacher and seven students. This information confirms that Joe Stoddart knew the group was going to canoe to Charmouth; it also suggests that his knowledge of the size of the group was insufficient.

- 54 At 1516hrs the Coastguard despatched a coast rescue vehicle from Lyme Regis. The purpose was first to search along the coastline and second from high vantage points to scan the sea with binoculars. This search did not locate any canoes or canoeists.
- 55 At 1551hrs the Coastguard decided to scramble the Portland helicopter.
- 56 At 1608hrs the Portland helicopter (a Sea King) arrived on site south of Golden Cap (see Map b in Appendix 7). The wind was now reported to be northerly, force 4 and the sea was moderate. The helicopter started to search.
- 57 At 1611hrs the Coastguard asked that the Lyme Regis inshore rescue boat be launched; it was in the water by 1630hrs approx.
- 58 At 1629hrs the Coastguard received a telephone call from Joe Stoddart with positive identification that the canoe found by the Spanish Eyes which had now returned to harbour belonged to his Centre.
- 59 At 1630hrs the Coastguard requested further helicopter assistance from Portland. A second Sea King was launched. It was joined by a Wessex from RAF Chivenor. Also launched was a Lynx helicopter from HMS Beaver which was in the area. This was now a major search and rescue operation.
- 60 At 1655hrs the first sightings of empty canoes were made by the Chivenor helicopter (see Map(b) at Appendix 7 for location). The Lyme Regis inshore rescue boat was directed to the location and recovered six canoes. No persons were sighted.
- 61 At 1730hrs approx, a helicopter sighted two canoes with occupants off West Bay in Bridport. These were Anthony Mann and Norman Pointer. The Lyme Regis inshore rescue boat recovered them and put them ashore at 1738hrs where an ambulance took them in to Bridport from where they were taken by helicopter to Weymouth. Norman Pointer had no spraydeck and no paddle. He was being held on to by Anthony Mann whose canoe and equipment were intact.
- 62 At 1734hrs the first person was lifted by helicopter from the water.
- 63 At 1746hrs a further five persons were lifted by helicopter.
- 64 At 1804hrs the Wessex from Chivenor picked up two persons.
- 65 At 1844hrs Emma Hartley, the final member of the group not accounted for, was located by the fishing boat Aranatha and was picked from the

sea by helicopter. Thus the final person picked from the water was recovered almost precisely four hours after the first report of a canoe being found had been made to HM Coastguard.

- 66 The inshore rescue boat appears then to have recovered more canoes before, like the helicopters, returning to base. At this time the wind, which had started the day in the South West, shifted to North, and then North West, was once again in the South West.
- 67 Whilst all this was taking place at sea it is pertinent to raise the question of what was happening on land. John Ellis and one group had gone to Dartmoor. The other group had gone dinghy sailing to the west of the harbour during the morning but had returned to the Centre apparently somewhat earlier than planned in view of the difficult sailing conditions (see paragraph 33 above).
- 68 The dinghy group, led by an instructor Jim Wilkins, had been accompanied by a safety boat. This was crewed by Glynn Upham. There is no evidence that when the dinghy group returned to shore the safety boat set off to look out for the canoeing group. The safety boat used by the centre was a Dell Quay Dory. It is doubtful that it could adequately have fulfilled a rescue capability in terms of recovering canoeists.
- 69 By about midday, the dinghy group had returned to the centre. Glynn Upham is reported to have returned at the same time. Joe Stoddart told investigating officers from the County Council that almost immediately he set out by car along the shore road as far as Charmouth; that there he walked some way up Golden Cap; that he returned to Lyme Regis where he embarked in the safety boat and went as far as half way along Golden Cap before returning to Lyme Regis; that during this passage there was a squall which caused him some difficulties; that he reported the fact that the canoeists were missing at some time around 1430hrs to the Harbourmaster before again taking the safety boat this time almost as far as Eype.
- 70 We have no information as to the activities on land of Glynn Upham or other Centre staff. The morning dinghy group had been scheduled to canoe in the afternoon and gathered for that purpose at about 1300hrs after a buffet lunch. During the afternoon they did a problem solving exercise and used a trampoline at the Centre in place of any canoeing.
- 71 At the St Albans Centre, John Ellis, with the Dartmoor group, arrived back by approximately 1700hrs. A member of the Centre staff immediately reported that there was a problem with the canoe group - but the seriousness of that problem was not made clear. A canoe had been found and three canoeists were missing but thought to be sheltering somewhere along the coast. 'To be on the safe side' John Ellis telephoned the Acting Head of Southway, June Mowforth, to let her know what the situation was. He recalls that June Mowforth said she would contact the Chairman of Governors. Not long afterwards John Ellis 'phoned June Mowforth for a second time to say that canoeists were being lifted from the water. June Mowforth told him she would go

into school and arrange to contact parents.

- 72 Because he did not have a high level of concern as to the facts reported to him, particularly because he believed the students to be with competent qualified instructors, John Ellis and the rest of the party took their evening meal and only after that did he, and the rest of the party, come to appreciate that something far more serious than he had been given to understand had happened.
- 73 His concern was both for the missing party and for the fifteen students at the Centre. They learned from television reports that one student had died. At approximately 2230hrs June Mowforth identified to John Ellis the name of the student who had died and further advised that four others were critical in hospital.
- 74 During the night of 22/23 March three more Southway students were pronounced dead at Weymouth Hospital. Emma Hartley remained in the intensive care unit. The condition of the other six survivors was stable giving no cause for concern.
- 75 Later that week Norman Pointer and the four students who survived were discharged from hospital.
- 76 Simon Dunne, Claire Langley, Dean Sayer and Rachel Walker died.

MANAGEMENT OF THE INCIDENT

- 77 Some time before 1800hrs on 22 March, John Ellis telephoned June Mowforth at her home to advise her that the canoeing party was overdue. He was not aware of the seriousness of the position but, nevertheless, felt the Acting Head should be notified (see paragraph 71 above). John Ellis was calm and measured.
- 78 June Mowforth contacted the Chairman of Governors, Dennis Camp.
- 79 At approx 1820hrs national BBC Television news inserted into its programme a newsflash of a tragedy involving a party of pupil canoeists in Lyme Bay. The name of the school involved was not given but local BBC Spotlight at 1830hrs led with the item and named the school.
- 80 By this time June Mowforth's telephone line had been blocked by incoming media calls; she had to use a neighbour's telephone to communicate. She made arrangements to go back to Southway asking Dennis Camp and senior staff to join her. Just before she set out to return to school she was contacted by police HQ at Middlemoor, Exeter, who stressed to her that she must prepare to deal with a situation developing rapidly into one of the utmost seriousness.
- 81 LEA officers based at Exeter and at Plymouth also reacted to the news reports. Deputy Chief Education Officer, John Wright, Area Solicitor, Julie Shrimpton and Area Education Officer, Paul Davies,

reached the school before 1930hrs. Also in attendance from the outset was Tony Loosemore, Head of Estover Community College. Senior staff at County Hall were in touch with Southway via the Community Education office there by 1900hrs while June Mowforth was still en route to the school.

- 82 Staff at the school joined others there when they heard the news; contact was made with many parents. Governors, local clergy and friends of the school quickly arrived. The media too turned up in force - one of the County Council's press officers had set off from Dawlish to the school at 1845hrs. Officers of the Devon and Cornwall police arrived and provided a ready link with Dorset Police who were, by then, in charge of incident response in Lyme Regis. Devon Social Workers from the local office also arrived in response to emergency procedures co-ordinated by the police. In the following days social workers made arrangements for counselling of parents and others - arrangements which will remain available for some time.
- 83 Some parents had gone direct to Dorset upon learning of the tragedy. Rachel Walker's father, upon hearing the news reports, managed to contact ALL HQ and then the St Albans Centre where he spoke to John Ellis. As a result of what he learned he and Mrs Walker set off immediately for Weymouth. Most parents went in to the school. Staff, governors and friends gave what comfort and support they could to parents. Virtually none of those involved had had previous experience to prepare them for the events of that day.
- 84 Whilst national and local news reports were building up a picture first of the loss of one life and later of four deaths and at least one critical casualty, staff and governors in Plymouth were not in a position to identify to parents that Simon Dunne had died and other students were in a critical condition until they received a fax transmission from Dorset police just after 2100hrs. Parents have subsequently commented that they did not understand the delay. It appears that the time lapse arose from the fact that the incident occurred nearly 100 miles from Plymouth - identification of those involved was made by Norman Pointer as soon as he was in a condition to do so. Moreover, the police advised that parents should not be advised by the school of names until they had received the names in documentary (fax) form. Sadly, this added to the trauma of the parents and there will remain forever with some the belief that had they been told earlier that their son or daughter was one of those in a critical condition they might have been able to reach Weymouth in time to pull back their son or daughter from the brink of death.
- 85 Families, friends and police made arrangements to take parents to Dorset late on 22 March and in some cases organised medical support for parents before taking them.
- 86 On the evening of 22 March, difficulties were encountered by the small number of telephones with operable outside lines at Southway; one governor brought in a mobile telephone to help; the single fax line there was vital. At Exeter's County Hall difficulties were

encountered in seeking BT assistance for external calls - the sophisticated network there preventing outgoing requests for assistance to BT and requiring these to be routed via the County Hall switchboard, a facility not available after 1800hrs.

87 Communication facilities are vital in response to an incident such as this. It is clear that more assistance could have been provided at Southway either via the Fire & Rescue Service or via the County Engineer's or Devon Direct Services Departments, all of which have up-to-date radio and telephone facilities. None of this was requested. Social Services staff at the school hired in further facilities which had to be brought in by despatch rider from BT in London.

88 From early evening on 22 March for several days the interest of the media was intense without ever becoming offensive. Supported by the County Council's press and public relations team the school was fortunate in being able to call on June Mowforth, Dennis Camp and John Wright to deal with media enquiries. They avoided speculation; they concentrated on fact; they played a leading role in opening up and sharing, particularly with the local community, the grief of the school. Throughout they remained calm and measured in their response to the situation with which they had been presented - as did John Ellis in Lyme Regis.

89 There was little Devon LEA support for the Dorset end of the incident. No one was deployed there to support John Ellis on the evening of 22 March. First Authority contact on 23 March with Norman Pointer in hospital was by an Authority Solicitor. The rest of the Southway party returned on 23 March in one minibus driven by John Ellis leaving the other minibuses at the Centre. The survivors of the canoeing expedition returned with parents variously during the rest of the week.

90 Dorset LEA made office facilities available in Weymouth from 23 March as a base for Southway staff. Very many offers of help from LEAs and elsewhere were received.

CONCLUSIONS

91 Schools have always been encouraged to arrange outdoor activities for their students. The introduction of the National Curriculum and the Technical and Vocational Education Initiative in secondary schools has highlighted awareness of the importance of not only the acquisition of skills and knowledge based on subject areas but also of extra-curricular, including outdoor, activities. The Devon County Council statement of Personal, Social and Moral Education recognises the importance of such activities and in particular, when linked with residential experience, of helping to develop the student as a whole person better equipped to take his/her place in modern society. The spirit of adventure and the desire of young people to undertake new and potentially hazardous activities should not be quashed.

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However, the quality of supervision and the preparation of students for these activities should be beyond reproach. In this case, however, quite simply this tragedy should not have happened. A series of errors and circumstances combined to cause the unnecessary deaths of four talented young people. The trip could have been better organised by the school. There was a clear failure to follow the guidelines and recommendations set down by the County Council. 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 suitably qualified staff and to have prepared and operated sensible and pre-determined procedures when difficulties arose.

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The reduction in the number of outdoor activity centres provided by Local Education Authorities has occurred at the same time as schools have been encouraged to give more and more students the experience of outdoor activities. Additionally, the pressure on Local Government finance, together with the ever-increasing demand to delegate a larger and larger proportion of the Education Committee's budget to schools has led to a reduction in public sector provision and the consequent increased opportunities for commercial organisations to enter what at present is an unregulated market. Finally, the County Council can learn from the whole incident and tighten up its procedures if such an emergency were to occur again.

We would like to record on behalf of the County Council our thanks to all those who supported Southway in the aftermath of this tragedy - individuals, groups, schools, medical staff, police services, clergy, members and officers of the Council and finally our particular thanks to the bereaved parents and the survivors who have helped us to compile this report.

County Hall
Exeter
Devon

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