

INTERIM REPORT - JULY 1993

THE LYME BAY CANOEING TRAGEDY

Preliminary recommendations from an interim joint report by Simon Jenkin, Chief Education Officer, and Philip Jenkinson, County Solicitor, Devon County Council on the canoe tragedy in Lyme Bay on 22 March 1993 which led to the deaths of Simon Dunne, Claire Langley, Dean Sayer and Rachel Walker, students in the Lower Sixth Form of Southway School, Plymouth.

Following the canoe tragedy in Lyme Bay on 22 March 1993, the County Council has undertaken an investigation into all matters relating to the incident, and, in particular, the School's planning for the visit, the sequence of events that led to the deaths of the four young people, the School's and the County Council's response to and management of the incident, and the making of any relevant recommendations for future action. The investigation has now been concluded as far as possible, but it is not possible to draw any final conclusions until all the evidence is to hand. Some evidence must inevitably await the Coroner's inquest and it is for that reason that the full report cannot be published at this stage.

However, there are three matters which we believe we can and should comment on immediately. They are:

- 1 the need for national regulation and registration of outdoor activity centres;
- 2 the County Council's regulations and the advice given to schools with regard to outdoor activities;
- 3 the County Council's emergency procedures.

1 **The need for national regulation and registration of outdoor activity centres**

We believe that the outdoor activity centres directly supported by Devon County Council conform to our own advice and regulation, in particular with regard to the use of qualified instructors. However, it is clear that Devon is not alone in reducing its own provision for outdoor activities and yet, at the same time, encouraging schools to give more and more pupils experience of outdoor educational pursuits and, in particular, residential activities, as part of their personal, social and moral educational programmes. The pressure on Local Government budgets, 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 this market. Recent media reports suggest that development of the private sector may not always be accompanied by the rigorous checking of qualifications and enforcement of safety standards undertaken by public sector organisations.

We believe, therefore, that a national independent system of registration and regulation of outdoor centres should be developed as a matter of urgency and, that once the system is established, no publicly funded school or youth group should be allowed to use any such centre until such time as it has submitted to registration and approval by the relevant body. We believe that the body ultimately responsible for registration and regulation should be the Health and Safety Executive, which should draw up a specification in conjunction with the regulatory bodies for activities (where they exist); should commission standards for those activities where at present there is no regulatory body and which should take advice and impose minimum standards of housekeeping and other social supervision.

Whilst the Health and Safety Executive should be the body responsible for such registration, inspections could be undertaken by any public private or voluntary body, which satisfies the Health and Safety Executive upon its invitation that it is competent to undertake such

inspections on the HSE's behalf. It is suggested that individual centres should be registered in respect of specific activities, provided they conform to the approved regulations: the application for registration should be the subject of a charge to the individual centre.

The regulation and supervision function should not apply to outdoor activity hostels owned by individual schools and run solely for their own use. The responsibility for such activities should remain with the governing body and the headteacher of the relevant school. However, if that school wished to hire its facilities to other schools or organisations for a charge, then it would be the subject of the requirements laid out above.

It is also recommended that the registration and regulation requirements should not apply to private organisations who recruit at individual level, for example, sailing clubs. The organisers and parents of the young people concerned should take responsibility for their own affairs in these instances. We do not wish to see a reduction in the number and type of outdoor activities undertaken by young people, and we recognise that there will always be a degree of risk when young people undertake such activities. However, we believe that in the light of the available information a national system of registration is inevitable and indeed desirable. It should include the recording and monitoring of details of individuals' qualifications; provide for reports of accidents and near miss incidents, and the Health and Safety Executive should report publicly each year on its work in this field.

2 The County Council's regulations and advice to schools

As Local Education Authority, the County Council has issued guidance and regulations for off-site activities in a document entitled "Safety in Outdoor Education". The current edition dates from 1990. In summary, the document covers all activities likely to be undertaken by schools, and the regulations follow the advice given by the national regulatory bodies for each of those activities. For example, in the case of canoeing it is the British Canoe Union's

guidance that is followed in the County Council's paper. Amongst other things, attention is drawn to a "Checklist for the use of commercial, charitable and private facilities" which appears on page 15 of the County Council's document.

We have considered the guidance offered in great detail, particularly the checklist, and have come to the conclusion that there is nothing that the County Council could add at this stage to improve upon it by way of regulation and advice. Reliance on the checklist has always depended on open and honest answers from centres to the questions set out. However, we do believe it important that we bring to the attention of schools the importance of the regulations and advice once again and, in particular, the importance of working through the full checklist. The Chief Education Officer will, therefore, be writing to all Heads and Chairmen of Governors bringing this matter to their immediate attention.

3 The County Council's response

The County Council's response was swift both at Southway in Plymouth and at County Hall in Exeter. At Southway governors, teachers, officers from the Education, Social Services and Solicitor's Departments and others offering a range of specialist knowledge and support arrived in urgent response to the news broadcasts. Equally, an ad hoc incident room was quickly established at County Hall in Exeter. There are lessons to be learned, however, from all such incidents. Communication facilities are vital. The County Council will wish to give consideration to how fax and telephone facilities can be rapidly supplemented to cope with the requirements of such incidents. Similarly, the County Council will need to look carefully at the support which it can give to any of its parties involved in such incidents which occur outside the County's boundaries.

SUPPLEMENTARY REPORT - DECEMBER 1994

- 1 On 15 November 1994 a jury at Winchester Crown Court was sworn in to hear charges brought against Peter Kite, Managing Director of OLL Limited (which was the new name for ALL), Joseph Stoddart, Manager of the St Albans Centre at Lyme Regis and OLL Limited. The charges are set out in Appendix 12.
- 2 The evidence presented by the prosecution substantially mirrored that which our original report of July 1993 had set out. Since, however, we did not attempt for the purposes of preparing that original report to interview in detail, or in some cases at all, witnesses who might be called to give evidence in any criminal proceedings there are some modifications, additions and clarifications which can now be provided to what we then found. These are set out below.

Paragraph No in Original Report	Modification/ Clarification/ Addition	Comment
Para 15 (d)	'A'	In cross-examination John Ellis confirmed he had given an average age of 18 for the group whereas it should have been lower. He also advised that in a telephone call to Stoddart he had said he wanted them "stretched a bit" in the activities. In re-examination he explained this latter comment as meaning he "did not want them sent on pleasant walks around the Centre".
Para 29	'A'	Norman Pointer gave evidence that there was no practice of re-entering a canoe from the water, simply climbing in from the edge of the pool.
Para 34	'A'	In evidence Steven Gynes gave the opinion that Karen Gardiner lacked confidence but had more ability than she gave herself credit for; in contrast that Anthony Mann had more confidence in his ability than was realistic. In his evidence Anthony Mann described himself as a confident and competent canoeist though he had never received any training to take people out on the open sea.

Para 35	'C'	Anthony Mann's evidence was that he, rather than the Centre, had provided a tow rope.
Para 39	'C'	Norman Pointer gave evidence that only when they reached the harbour was he aware that they were to paddle to Charmouth.
Para 41	'A'	Norman Pointer gave evidence that when he could not longer see the group he told Anthony Mann to blow his whistle (Norman Pointer's lifejacket not being equipped with a whistle) but Mann did not.
Para 45	'C'	Karen Gardiner alone had a watch. Her evidence was that at 13.30 all canoeists in the group had capsized and were in the water.
Para 49	'A'	Norman Pointer's evidence included reference to dry land training of how to put a lifejacket on; that they were told they could blow it up a little more if necessary but this would be very rare. In her evidence, Joanna Willis said she had not inflated her lifejacket because she "had been frightened about what [she] had been told on shore that there was a danger that it could be over-inflated or even deflated". The evidence of Lt Commander E Oakley was that the single most effective factor leading to the four deaths was the failure to inflate lifejackets - in effect the group had entered the sea not wearing lifejackets.
Para 51	'A'	In evidence the skipper of the Spanish Eyes, Paul Wasson, confirmed his initial thoughts to be that the canoe had drifted off from the shore having been left insecure and he did not think anyone was in trouble at the time.
Paras 51-66	'C'	HM Coastguard were closely questioned at the trial as to

their handling of the developing situation. Concerns were raised as to alleged breaches of their standing orders, as to chains of command, as to instructions to helicopter pilots on search patterns. In the course of evidence A C Day conceded that a helicopter and lifeboat search should have commenced by 15.36.

Para 53	'C'	The evidence of A C Day of HM Coastguard was that Stoddart had referred to seven 18-year old <u>boys</u> ; that the instructors were competent; that there was an on-shore wind; that they had flares; that they were 2 [not 3] hours overdue.
Para 68	'M'	Glyn Upham gave evidence that after the dinghy group came ashore at 11.20am he went to see where the canoe group were and when they had not returned he went along the coast to Charmouth in the safety boat.

- 3 We have also been able to take up with the Chief Constable of the Devon and Cornwall Constabulary the perception of a delay in identifying those involved - Para 84 of our report refers. The situation in Dorset was understandably confused; many of the survivors were in trauma and in intensive care. Following discussions involving the Dorset Police and June Mowforth a decision was taken to release the names of the survivors and the deceased when confirmation by telex was received from Dorset, and the position was clearly established and support was available for the families involved. It would have been unforgivable to inform parents that their child had died or survived if that was not the case. Both the Dorset and the Devon and Cornwall Constabulary followed approved major incident procedures.
- 4 Finally, paragraph 11 of our report referred to the County Document "Safety in Outdoor Education" which is annexed at Appendix C. At the time of this tragedy the document was undergoing a periodic review and a revised version has since been published.

S W G Jenkin

P Jenkinson

December 1994