Adventure Activities Licensing Authority Board Meeting
8th October 2013

Adventure Activities Licensing Service Operations Report
March 2013 – August 2013

1. Number of Licence Holders

At the end of August this stood at 1244

Previous figures at the end of July 2013 - 1237,
June 2013 - 1230,
May 2013 - 1230,
April 2013 - 1214,
March 2013-.1219.

2. Relevant Action

During the reporting period, four providers were issued with a notice that we were considering refusing their licence renewal application. Three providers subsequently satisfied us that our concerns had been addressed and the notices were rescinded. A fourth provider did not provide the required information and their renewal application was refused. They subsequently re-applied, were found to have satisfied our concerns and a licence was issued.

One provider, A Local Authority, was issued with a notice that we were considering varying their licence. This case is still in progress.

See Appendix 1 for more detail.

3. Recorded Accidents and Incidents

3.1 Summary.

After the end of the reporting period we received news of the death of an adult male at Hollingworth Lake Water Activity Centre on 5 September whilst taking part in a led open canoeing session. The centre holds an Adventure Activities Licence. The incident is under investigation by the police and HSE and there has been no release of information beyond what was reported in news accounts at the time. However, we have received unconfirmed reports that the man removed his buoyancy aid before jumping into the water.

During the reporting period 18 accidents/incidents were entered on the Licensing Service's database. 15 of these occurred during the reporting period and 3 were entered retrospectively as information was received.

Of the 15 cases which occurred during the reporting period, 7 involved fatalities. 2 of the 7 cases involved the deaths of young people – an 11 year old girl was found dead in her bed at a licensed centre (thought to be from natural causes) and an 8 year old girl was killed along with her 51 year old father in a RHIB accident.

Of the 5 further cases involving adult fatalities, a 61 year old male died when he collapsed in the Cairngorms, 3 Ministry of Defence personnel died during/after taking part in a Territorial Army selection process in the Brecon Beacons, a 54 year old male died after falling 24 metres whilst he was mountain biking with friends, a 24 year old instructor from a licensed centre was found dead in the Picos de Europa mountains and a 48 year old male novice kayaker drowned after capsizing in bad weather on Loch Morar.

Of the 3 cases which occurred prior to the reporting period and entered onto the database retrospectively, 1 involved a fatality – a 7 year old girl drowned in a leisure centre swimming pool.

A further 8 accidents/incidents which have been reported previously were updated as more information became known. In 7 cases the update related to inquest verdicts or legal action. 2 updates related to ongoing investigations.

Details of all 26 cases are attached at Appendix 2.

3.2 Significant lessons learned from these and other recent incidents and fed back to the sector include:

-The importance of kill-chords to automatically cut off the engine should the driver of a power boat go overboard.

- The need to safeguard instructors and employers, not just clients and to ensure they work well within their competence levels.

- The risks associated with instructors teaching beyond their abilities after a school was prosecuted following an accident when teaching staff were teaching lead climbing without being trained how to do so safely.

- The danger of using safety equipment that is too complicated for the levels of experience of those expected to us it.

- To be cautious in the face of extreme weather.

-The danger of hyperthermia (heat exhaustion.

- The danger of being ‘hung up’ by a helmet or clothing when being lowered by an auto-belay device.

- The importance of ‘equalising’ the ends of a climbing rope before abseiling on it.

- The previously poorly understood danger of an accidental reconfiguration of climbing equipment which can result in a rubber ‘retaining’ band inadvertently becoming an integral part of the load bearing chain.

New Info Log Entries

During the reporting period the following new Info Log entries have been sent to the Institute for Outdoor Learning (IOL) for publication on their website:

- Refilling meths stoves – advice on avoiding accidents following a very serious and near fatal accident.

- Reverse polarity in compasses – advice to check whether mobile ‘smart’ phones and other devices are having a significant effect on the compass needle following recent reports.

- Climber ‘hung up’ by her helmet

Marcus Bailie
Head of Inspection
23.09.13

Appendix 1

1. **Action Taken: Minded to Refuse licence; Refused**

   Following receipt of a renewal application, an inspection was carried out on 7th February 2013. The inspector was not satisfied that there was evidence of periodic thorough checks on all safety equipment.

   As a result a Notice that we were considering refusing their renewal application was sent to the provider on 1st March 2013. The provider did not provide the required information and subsequently, on 8th April 2013, a Notice was sent to the provider to advise that their renewal application had been refused.

   The provider provided the required information later in the month and their licence was renewed as from 29th April 2013.

2. **Action Taken: Minded to Refuse licence; Rescinded**

   Following receipt of a renewal application, an inspection was carried out on 10th May 2013. The inspector identified failures in the following areas:

   - Failure to create a system which ensures that only equipment which has been assessed by a competent person as being fit for purpose is issued to participants.

   - Failure to create a system which enables a clear audit trail for each itemised safety critical item, showing when it was inspected, by whom and what that inspection comprised.

   As a result a Notice that we were considering refusing their renewal application was sent to the provider on 16th May 2013.

   The provider subsequently provided information that satisfied our concerns and their licence was renewed.

3. **Action Taken: Minded to Refuse licence; Rescinded**

   Following receipt of a renewal application, an inspection was carried out on 28th May 2013. The inspector identified failures in the following areas:

   - Failure to have robust evidence that staff are competent to lead and/or assist the activities to which they are assigned, including seeing relevant qualifications and putting copies on file. Suitable records of induction, further training and periodic monitoring also need to be developed and maintained.

- Failure to review the risk assessments to ensure that they remain fit for purpose and are consistent with current operating procedures.

As a result a Notice that we were considering refusing their renewal application was sent to the provider on 5th June 2013.

The provider subsequently provided information that satisfied our concerns and their licence was renewed.

4. **Action Taken: Minded to Refuse licence; Rescinded**

Following receipt of a renewal application, an inspection was carried out on 10th July 2013. The inspector identified failures in the following areas:

- Failure to ensure that the records of staff awards is complete and up to date.

- Failure to ensure that each person who leads an activity has a clear statement of competence issued by an appropriate person, and to ensure that this is kept as evidence in their file.

- Failure to ensure that a log is kept of who is afloat, and other pertinent information, and that this is checked to say they have safely returned.

As a result a Notice that we were considering refusing their renewal application was sent to the provider on 16th July 2013.

The provider subsequently provided information that satisfied our concerns and their licence was renewed.

5. **Action Taken: Varying a licence.**

At an inspection carried out on 24th July 2013 the inspector identified that the provider had not completed an audit and to monitor provision of activities by its various services and establishments.

The inspector further found that the provider was failing to satisfactorily exercise their responsibilities to manage the activity provision by its services and establishments.

As a result we issued a licence to cover one centre only. The provider is making progress with addressing the issues elsewhere in the organisation. If these are satisfactory we will reverse the decision to vary the licence.

Appendix 2 – Logged Incidents

Occurred during the Reporting Period

1) July 2013 - A 24 year old male was found dead in the Picos de Europa mountains after being missing for several days. He was an instructor for a licensed provider and had been assessing a DofE expedition for a school. He took an alternative route by himself towards the group's first overnight campsite and, when he didn't arrive, was officially reported as missing the following morning. His body was found 4 days later following a major air and land search by Spanish police. It was understood that he slipped and fell to his death.

2) July 2013 - A 9 year old girl was descending a climbing wall in a shopping centre when her helmet got caught on one of the holds. Her mother reported that "she was left dangling on the wall, whilst the helmet strap strangled her neck.and the rope tried to descend." Her mother has alleged that the provider did not react quickly enough to the incident. The business has been suspended from operating in the shopping centre whilst the incident is investigated. The local EHO requested assistance. A senior inspector contacted him and, having received information regarding the incident from the EHO, offered advice and assistance via e mail.

3) July 2013 - A 54 year old mountain biker died after falling up to 80' (24m) in the Peak District, Derbyshire whilst cycling with friends. Mountain rescue volunteers, along with an air ambulance and a police helicopter spent 6 hours attempting a rescue but the man died. An inquest was opened and adjourned at North Derbyshire Coroners Court.

4) July 2013 - 3 Territorial Army soldiers died after taking part in the selection process for the Territorial SAS reservists in the Brecon Beacons. One died on the mountain, one 3 hours later in hospital and a third 2.5 weeks later. A total of 6 soldiers collapsed in the hot weather (it was the hottest day of the year, with temperatures reaching 30C in Powys). An inquest on 24/7/13 gave the medical deaths of the first 2 casualties as 'unascertained' and advised that further investigations were being carried out. The inquest was adjourned. The coroner also warned that the MOD could face investigation under the Human Rights Act and said that "right to life" would play an important part in the inquest. An inquest in relation to the 3rd casualty found that he suffered multiple organ failure. Investigations have been launched by both the police and HSE. In September 2013 it was reported that a further pre-inquest hearing is due to take place in November and the full hearing is not likely to happen until Spring 2014.

5) June 2013 - A licensed provider had a hen party rafting on the Tummel at low levels. One of the rafts in the flotilla flipped on entry to a Grade 3 rapid and one lady fell out. She was shaken by the flip/swim but appeared uninjured and walked the bank to the egress point, accompanied. Nothing was reported by the party on return to base. A call came through the next day from the bride to be that her friend was seriously ill in hospital (ruptured

spleen and liver) and may not survive. The provider had an in depth review of the session and concluded there was nothing they would do differently. Full record kept of event and the review. They have now been informed that the injured person has recovered. The injured person was a very large lady. The provider has done some research on the internet and has found information that overweight and unfit persons are susceptible to organ rupture in the event of extreme physical movements.

6) June 2013 - An 11year old girl fell from a high ropes course at a licensed centre and broke 6/7 bones in her foot. It would appear that the landing was soft and she had no reported spinal injuries. The harness she was wearing was taken away by the EHO for inspection. The investigating EHO contacted AALS for assistance.

7) June 2013 - A 61 year old male died when he collapsed close to the summit of Beinn Bhrotain in the Cairngorms. He was part of a school walking group and was injured when he collapsed. He was airlifted from the mountain and was flown to hospital in Inverness but was pronounced dead on arrival. The remaining members of the group, thought to include 6 teenagers and 2 adults, were helped off the mountain by rescue teams. A police spokesman said that there were no suspicious circumstances.

8) June 2013 - A member of staff in their 3rd year with a licensed provider was accessing the Zip Wire to adjust the rubber blocks on the 'braking system'. She became detached from the system and fell approximately 5m breaking her arm and cracking one of her vertebrae. The Technical Advisor undertook a preliminary review of the information and indications were of 'user error' in the form of an 'incorrect attachment followed by non-adherence to system checks'. This was confirmed in the investigation. AALS assisted Weymouth & Portland BC.

9) June 2013 – A female councillor in her 40's fell from a zip wire and suffered serious pelvic injuries at a new high ropes course at a licensed provider. The course was brand new and had been due to open to the public a few days after this incident (now closed whilst investigations are carried out). Welwyn Hatfield Council requested assistance with their investigation from AALS. A senior inspector visited the site with an EHO and looked at the site of the incident and some of the equipment.

10) May 2013 - An 11 year old girl died whilst on a school trip to a licensed centre. She was found unconscious in the early hours of the morning and efforts to resuscitate her were unsuccessful. She was later pronounced dead at hospital. Police Scotland stated that a post mortem examination indicated that she died as a result of an abnormality in her heart, but full results not yet known.

11) May 2013 - A 51 year old and his 8 year old daughter were killed after they and the rest of their family were thrown out of their rigid hulled inflatable boat (RHIB) whilst they were manoeuvering the boat at speed in the Camel Estuary near Padstow. MAIB said that the driver was not using the vessel's

kill cord. Once they were in the water, the boat continued circling and ran over the family. The wife had her left leg amputated above the knee and she and their 4 year old son will need further surgery. The 2 elder daughters received minor injuries. The boat was brought under control after a few minutes by a local boatman who was able to board the craft to turn off its engine. An inquest was opened and adjourned.

12) April 2013 - Two kayakers on Loch Morar were caught in bad weather with gusts up to 40mph / 3-4 ft waves. Both capsized; they were reported to be wearing life jackets which was a requirement before going on the loch. One surviving male managed to swim to an island and raised the alarm the following morning. He was taken to hospital suffering from hypothermia. The victim was found in the water by a SAR helicopter. The loch is one of the deepest freshwater lochs in the UK with a maximum depth of 310m. This was reported to be the victim's first kayaking trip.

13) March 2013 - An instructor for a licensed provider was injured when he fell a distance of approximately 10m at The Portwall, Avon Gorge. He had been setting up the ropes for a climb with a group of young people and was abseiling back down to the group when he fell. An off-duty police officer who was climbing at the same site administered first aid whilst another member of the public called an ambulance. He suffered a badly broken ankle and had to have his pelvis pinned. Bristol CC requested assistance from AALS in their investigation.

14) March 2013 - Four teenagers were found safe and well after they had become separated from the adults they were with whilst training for Ten Tors. The alarm was raised at 7.45 pm on Saturday 9th March when the missing youngsters rang the police but were unable to give their exact location. It was reported that, although they were dressed appropriately, they had no shelter with them. The weather prevented the force helicopter from lifting and the Dartmoor Rescue Group was called in to take part in the search. Through thorough questioning of the missing people, the officers organised a systematic search and found them just after midnight at Fernworthy Forest suffering from the effects of cold. All four were allowed home once checked by medical staff.

15) March 2013 - On 8th March 2013 a group of 15 students and leaders set out on a Gold DofE pre practice training weekend on Dartmoor. What happened during the activity was eventful and at times traumatic. There is a detailed analysis of the event on file but in an anonymised format.

<u>Occurred prior to the Reporting Period</u>

16) January 2013 - Two adults who hold the SPA, employed a climbing instructor who holds the MIA, to enable them to gain experience relevant to taking MIA training. On the day of the incident they had planned to climb at St Govans Head but, as access was restricted, they moved on to Lydstep with the intention of climbing 'Rock Idol', a climb on Mother Carey's Kitchen cliffs. After an abseil descent the instructor led the climb and one adult climbed

second, belayed by the instructor from above. At some point, the adult fell, was not held by the climbing rope and landed in a rock pool at the base of the cliff sustaining serious injuries. The second adult moved him from the rock pool to higher ground. The instructor abseiled down to assist in moving him further due to the rising tide. During this the second adult dislocated his shoulder. The instructor then climbed the abseil rope to call the emergency services. The emergency services evacuated both adults to hospital.
AALS was asked to assist in the investigation.

17) June 2008 - A 7 year old girl died after she went swimming with a number of other children at an Essex leisure centre after attending a judo competition. Members of the public found her at the bottom of the pool's deep end. One of the lifeguards retrieved her from the water with the assistance of another swimmer. Despite resuscitation attempts she was later pronounced dead at hospital. At an inquest in May 2011 the jury returned a verdict of accidental death caused by immersion. The company which operates the pool was prosecuted by HSE in July 2013 after an investigation identified serious failings with lifeguard cover. They were fined £90,000 with £101,663 costs after admitting breaching Section 3(1) of the Health and Safety at Work Act. Media reports indicated that her parents were taking civil action against the company but no further information is known.

18) May 2008 - A 14 year old girl received serious injuries when the rubber ring in which she was being towed by a speedboat collided with a yacht during a family outing on the River Orwell, near Levington Marina, Suffolk. She suffered a fractured skull, brain injuries and a broken leg. In May 2013 she was awarded £1.73M in compensation, payable by the insurance company of the driver of the speedboat which was towing her. At the time of this compensation award, her father said that she had received brain injuries and was also left with impaired vision and hearing, partial loss of use in her left arm and reduced mobility.

<u>Updated during the Reporting Period</u>

19) Skiing Fatality – February 2013
A 13 year old girl died after falling from a chairlift 20' above the ground whilst on a school skiing trip in Claviere in the Italian Alps. It is reported that after the fall she got up and wanted to rejoin her friends on the chair lift but died from internal bleeding 20 minutes later. The trip was organised by a commercial provider. The director of the ski school at the resort said that the safety bar on the lift was down when she fell and that she fell 'standing up'.

20) Central Trinity Gully, Snowdon – October 2012
A group of 6 children aged 13-15 years and a teacher had to be rescued from Central Trinity Gully on Snowdon after getting lost. A weak mobile phone signal made it difficult for the group to contact anyone but they were eventually able to raise the alert. Volunteers from Llanberis Mountain Rescue located the group in poor visibility and had to individually rope each pupil and their teacher down a 100' cliff before leading them off the mountain. The rescue took 9 hours. It was reported that the group made a navigational error

- they had attempted to cross from the Pyg track to the Miner's path but ended up in a dangerous area. Two of the group had mild hypothermia. We believe the police arrested the leader on a lack of duty of care basis. In July 2013 HSE requested assistance from AALS with the investigation.

21) Climbing Wall Accident – October 2012
A child who was lead climbing on a wall within a school fell and injured his ankle. The child was being instructed by a member of PE staff and belayed by a fellow pupil. It appears that the child reached the fourth quick-draw having clipped the rope through the previous three and then fell. The teacher had gone across to the belayer to act as a 'tailer'. The climber hit the floor. HSE investigated the incident. Following a magistrates court hearing in June 2013 the school was fined £9000 plus £1641 costs after admitting a Section 3(1) charge.

22) Polar Bear Attack – August 2011
A polar bear mauled a 17 year old boy to death and left 4 others (2 leaders and 2 trip members) badly hurt in an attack on the remote Norwegian island of Svalbard. They were part of a party of 80 mainly 16-23 year olds on a trip organised by a licensed commercial provider. Reports suggested that a warning trip wire system failed to work and that a rifle failed to fire four times before it was successfully used to kill the bear. There was also no watch system in place overnight. In March 2012 it was reported that the Norwegian authorities had ruled that his death was preventable but that the leaders of the trip would not be prosecuted. His parents appealed the decision but in June 2012 the original decision not to prosecute was upheld by the Norwegian courts.

In September 2011 the provider announced that a high court judge had been appointed to chair an independent inquiry into the incident. A statement on the provider's website states that, at the request of the young person's parents, the report publication will be delayed until 2 weeks before the inquest. As at August 2013 no inquest date has been set.

23) Zip Wire Fatality – April 2011
An 11 year old boy died after falling from a forest zip wire ride at an activity park in Gwynedd. The park owners said that all equipment had been checked before the fatal accident and was in good condition. The ride had opened for the first time 6 days before the accident and was described as the longest zip wire ride in Wales, going to a height of 9m and spanning 145m across a wooded valley. He suffered severe head injuries in the fall and was air lifted to Bangor hospital where he later died. An inquest was opened and adjourned. A year later in April 2012 the media reported that an inquest would not take place until an investigation by council and police was completed. The local authority investigated and found that the accident was probably caused by him being mis-clipped onto the zip wire. This took place because the company taped up the tail end of the lanyard rope back onto the main lanyard to make the ends neat and tidy. An inquest in May 2013 returned a verdict of accidental death.

24) Parafan Descender – August 2010
A 22 year old instructor at a licensed provider was seriously injured on a fall from a parafan descender. He had changed the cable on the device and did a test jump, according to manufacturer's instructions. The cable didn't hold his weight and he fell 9 metres to the ground. It was later confirmed that he suffered a broken back and was paralysed from the waist down for 6 months. As he was regaining movement, it became clear that his ankle had been crushed and his right foot had to be amputated. An EHO from Tonbridge and Morling Council contacted AALS in January 2011 to ask for our assistance, particularly whether the provider could/should have done anything differently to ensure his safety. Advice also requested on parafan descenders.

In August 2013 HSE prosecuted the supplier of the ropes. Investigations had revealed that the company had used the wrong components and had not operated their quality control system when making the batch of rope eye-end terminations which meant that when the instructor jumped from the climbing tower, the rope parted from his harness and he fell to the ground. The company was fined £20,000 plus £6,348 costs.

25) Turkish Rafting Fatality – July 2010
A 9 year old girl died and her 12 year old male cousin was seriously injured when their inflatable boat capsized during a white water rafting trip with their family in Turkey. They were both thrown from the raft after it apparently hit rocks and overturned near the resort of Dalaman. Family members, a rafting instructor and the police searched for her for more than an hour before her body was found trapped between rocks. He was discovered badly injured and clinging to a rock. In July 2011 4 men (2 directors and 2 employees of the rafting company) went on trial in a Turkish court charged with causing death through negligence. Also in July 2011, following a year long campaign, her father received confirmation from the Turkish tourist authority that, in future, no-one under 17 or over 55 years would legally be allowed on the stretch of water where the incident happened. In June 2013 the 4 men were found guilty of "reckless killing" and were each sentenced to five and a half years in jail.

26) Scottish Coach crash – March 2010
A 17 year old died when the coach she was in overturned in "horrendous" weather conditions. She was with a party of 39 pupils and 6 adults who were heading for a day out at Alton Towers in Staffordshire. The coach appeared to have lost control in the snow and ice, struck a bridge parapet and left the road before landing on its side in the river. Police said that she was thrown from the bus and trapped under it. All of the passengers received hospital treatment, three for serious injuries. In January 2011 4 Strathclyde police officers received bravery awards for rescuing pupils from the bus crash. Following a Fatal Accident Inquiry, the sheriff's determination in May 2013 found that the standard of driving by the coach driver was the cause of the accident. She ruled that he was travelling too fast for the wintry conditions. She also found that the fatal outcome could have been avoided if the pupil had been wearing a seat belt.