Adventure Activities Licensing Authority Meeting
Tuesday 27th September 2011

Adventure Activities Licensing Service Head of Inspection report
March 2011 – August 2011

1. Number of Licence Holders

This stands at 1252 as at 31.08.11.

There is currently no indication of any down turn in the number of licence renewals. However, a significant reduction in Local Authority provision of residential adventure activities is anticipated.

2. Relevant Action

During the reporting period, four providers were issued with a notice that we were considering revoking their licence.

In all 4 cases the providers addressed our concerns satisfactorily and their licences continued.

See Appendix 1 for more detail.

3. Recorded Accidents and Incidents

During the reporting period, 25 accidents / incidents were entered on the Licensing Service's database. 17 of these occurred during the reporting period and 8 were entered retrospectively as information was received or records were updated.

Of the 17 cases which occurred during the reporting period, 6 involved fatalities – 3 young people under the age of 18 years and 3 adults.

Of the 8 cases which occurred prior to the reporting period and entered on to the database retrospectively, 5 involved fatalities - 3 young people under the age of 18 years and 2 adults.

Of the 6 young people who died, 2 involved falls from height, one from a zip wire and one from the mast of a sail training ship. 3 fatalities occurred abroad and were due to electrocution, a polar bear attack and suspension from a ski lift. The remaining fatality occurred during a kayak marathon event.

Of the 5 adults who died, 2 incidents happened abroad: a rafting accident with a commercial company and a fall from height from a bridge swing. The remaining 3 fatalities involved activities within

peer groups: kayaking, cave diving and powerboating (the latter of which had links with a licensed provider).

Details of all 25 incidents are shown in Appendix 2.

Appendix 1

1. **An outdoor education centre in Scotland**
   Action Taken: Minded to Revoke licence, Rescinded
   Following receipt of a renewal application for a licence which expired on 6th June 2011, the Centre was inspected on 5th April 2011. The inspector identified failures in the following areas:

   - Failure to maintain a robust process to ensure that those who carry out the training of their tutors are subject to regular monitoring and receive ongoing training and mentoring in their management of training and assessments by a technical advisor.

   - Failure to validate the documented risk assessments and Standard Operating Procedures.

   As a result a Notice that we were considering revoking their current licence was sent to the provider on 12th April 2011. The inspector had a further meeting with representatives of the provider on 10th May 2011 at which both its centres were discussed. He was satisfied that appropriate action had been taken to address our concerns. The licence therefore continued and was renewed as from 6th June 2011.

2. **An outdoor education centre in Scotland**
   (R0702) Action Taken: Minded to Revoke licence, Rescinded
   Following receipt of a renewal application for a licence which expired on 29th June 2011, the centre was inspected on 6th April 2011. The inspector identified failures in the following areas:

   - Failure to maintain a robust process to ensure that those who carry out the training of their tutors are subject to regular monitoring and receive ongoing training and mentoring in their management of training and assessments by a technical advisor.

   - The task of being Technical Advisor, Programme and Tutor Development Manager and Centre Manager is proving too much for the present incumbent.

   As a result a Notice that we were considering revoking their current licence was sent to the provider on 12th April 2011. The inspector had a further meeting with representatives of the provider on 10th May 2011 at which both its centres were discussed. He was satisfied that appropriate action had been taken to address our concerns. The licence therefore continued and was renewed as from 29th June 2011.

3. **Outdoor activities centre near Sheffield: Minded to Revoke licence, Rescinded**

On 6th April 2011 the inspector carried out an unannounced visit to the centre. This was made to follow up an earlier renewal inspection which had taken place in November 2010 during the centre's winter closure period. During this visit the following failures were identified:

- There was no-one at the centre with the experience, technical ability or dedicated time to monitor and manage the predominantly young and inexperienced staff, as opposed to writing programmes of activity and allocating staff to it.
- The centre was unable to provide evidence of the training, competence and accreditation of instructors.
- The written operating procedures examined were confusing, inadequate and hugely over complicated.

As a result a Notice that we were considering revoking their current licence was sent to the provider on 27th April 2011. Following a meeting with the provider on 23rd May 2011 the inspector was broadly satisfied that the provider was taking steps to improve the system of training and monitoring instructional staff and the Notice was rescinded.

4. **A provider in Derbyshire Action Taken: Minded to Revoke licence, Rescinded**

Following numerous unsuccessful attempts to contact the provider, the inspector made an unannounced visit on 26th April 2011 in an attempt to see an activity session take place. The following failures were identified:

- It was not clear how adventure activities were managed.
- There was inadequate evidence of competence of the leaders for the activities offered.
- It had not been possible to view an activity and ensure that the delivery of activities was consistent with the written procedures seen in various documents and claimed by management.

As a result a Notice that we were considering revoking their current licence was sent to the provider on 9th May 2011. A further visit and an activity inspection were carried out by the inspector and as a result of his findings on these visits, the Notice was rescinded and the licence continued.

- **Appendix 2**

Details of the 25 accidents / incidents entered on the AALS incident data base.

Incidents which occurred during the reporting period

a) March: An EHO from Greenwich Council contacted AALS to request information on abseiling as part of her investigation into an accident which happened during a charity abseil event run by a commercial company at the O2 Arena. She advised that the safety rope had become caught and it was not possible to lower the injured party, a woman in her 50's. The decision was made to cut the safety rope, the injured party fell to the ground and was air lifted to hospital. The injured party was believed to have fallen around 25' and thought to have suffered a broken arm.
Greenwich Council requested assistance from AALS in their investigation (expert opinion, report and appearance in court as an expert witness if prosecution follows).

b) March: A group from an unlicensed provider were at a pool near the silica mines in the Dinas Rock area. A participant broke his/her leg and was evacuated by helicopter. AALS have had previous contact with the provider regarding advertising licensable activities when they do not hold a licence. They have previously advised that they subcontract these activities to a licensed provider. The inspector met with the provider in the office (at the provider's request) and the incident was discussed. It was found to be an all adult group and therefore not a licensable activity.

c) April: A 22 year old male died after getting into difficulties while on Ullswater. He was kayaking the length of 3 lakes with a friend when he is believed to have capsized in the choppy waters. He was recovered from the water but was pronounced dead on arrival at hospital. His friend in the two man racing kayak managed to make his way to shore.
This incident is believed to be only the second ever flat water drowning whilst wearing a buoyancy aid.

d) April: A15 year old suffered serious injuries when he fell off his mountain bike during a downhill event organised by a commercial company in Shropshire. He broke his neck in 5 places and fractured his sternum but, luckily, suffered no spinal cord damage. His father phoned AALS to ask about guidelines for inspection of event courses.

e) April: An 11 year old boy died after falling from a forest zip wire ride at an activity park in Gwynedd. He suffered severe head injuries in the fall and was air lifted to Bangor hospital where he later died. The ride had opened for the first time 6 days before the accident. The local authority investigated and found that the accident was probably caused by him being mis-clipped onto the zip wire. It was thought that this happened

because the company taped up the tail end of the lanyard rope back onto the main lanyard to make the ends neat and tidy, thereby creating a false loop which he was subsequently clipped onto.

f) April: While cave diving in Clydach Gorge, a 52 year old experienced cave diver failed to surface with her two diving partners. Her body was recovered by one of the group. It is believed that she had become disorientated in the cave and lost the guide line.

g) April: A 6 year old girl nearly asphyxiated whilst on an indoor climbing wall. She was harnessed, fitted with a helmet and attached to an inertia wire. Having lost her foot and hand holds, she twisted on the wire and the plastic adjustment strap at the back of her helmet caught on one of the projections, suspending her weight by the chin strap. It took members of the public and staff members several minutes to climb up and release her, by which time she was blue. She did not suffer any physical long term effects.

The local EHO investigated and provided the details to AALS. An Info log is to be put on website re lessons learned.

h) May: The Outdoor Education advisor for Buckinghamshire contacted AALS to advise of a serious quad biking accident at an unlicensed commercial centre. A young schoolboy was airlifted to hospital with a suspected fractured hip and pelvis. AALS was later advised that the boy was discharged and he returned to join the group. He did not appear to have suffered any serious injury.

i) July: The Executive Director of a licensed centre phoned to advise of a fatality involving the club. A seasonal staff member borrowed a power boat (with their permission) and took 2 other young males around the harbour. One of the passengers fell out and was struck by the boat. He was taken to hospital by helicopter but died of his injuries. No other boats were involved.
Police are investigating. RYA, HSE and MAIB have been informed and are not thought to be taking any further action.

j) July: An EHO from Plymouth Council phoned to seek advice on mobile climbing walls (particularly the training and competency levels required for operators) following an incident at a school fete. An adult fell to the ground, sustaining unknown injuries which led to him being off work for a week. It has been found that the rope had been clipped onto the equipment loop of his harness in error, which did not hold his weight when he came off the wall. A senior inspector spoke to him on the phone. As well as informing him on relevant issues, such as staff competence, training etc., he informed him that we would be able to provide further support, in the form of a joint visit, if required.

k) July: A 17 year old male was taking part in a marathon event on the

River Thames when his kayak capsized. He was last seen by an eye witness holding onto his overturned canoe and swimming with it to the river bank. Rescuers recovered his body a day later. It was reported that he was not wearing a buoyancy aid. He was an experienced canoeist and a member of a canoe club.
Police are treating his death as non suspicious and the local authority and HSE have been informed.

l) July: Derby Mountain Rescue Team were called to Black Rocks, near Cromford where a 19 year old woman had suffered a head injury after falling over a rocky ledge. She was one of several group leaders with a party of 20 children who were climbing with a licensed provider. Information received from the provider describes how the instructor was spotting 3 members of the group down an awkward step on a descent route while the rest of the group, including the injured party, were told by him to wait and not move. The instructor was just going up to help down 3 more group members when he saw the injured party come to the edge. He shouted at her to get back but she lost her balance, slipped and hit her head when she landed on the ground. She was evacuated by mountain rescue stretcher to a waiting helicopter and transferred to hospital in Nottingham. Full extent of injuries not known but she was wearing a helmet at the time.

m) August: A group of 8 young people aged between 17 & 25 years plus 2 accompanying adults on a Princes Trust team programme were trapped by rising water in Long Churn cave, North Yorkshire. They were on a caving trip led by a licensed provider. The Cave Rescue Organisation was alerted by an army based caving group who saw the group enter the cave. They were led out of the cave when water levels dropped several hours later. Paramedics carried out precautionary medical checks and all those involved were declared fit and well.

n) August: 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 the British Schools Exploring Society, a licensed provider.

o) August: During a renewal inspection of a licensed provider the inspector was advised of an incident involving a child becoming detached from the zip line and falling approximately 8m onto soft ground. Because of the height of the fall, the potential for very serious injuries and the remote situation, the emergency services were contacted immediately. The boy was taken to hospital by helicopter and was found to be without serious injury: he had a cut to his chin which needed stitches. The provider has carried out an internal investigation and it appears that there was a mis-clipping of the doubled sling that attached the participant to a karabiner on the zip line cable. Additional measures have now been put in place to prevent the incident happening again.

The inspector was of the opinion that the accident was caused mainly by human error and made it a requirement on his report that the provider is to seek advice and endorsement from a suitably qualified technical advisor on the proposed changes to the equipment and procedures for the zip line activity.

p) August: A 44 year old man was rescued from the bottom of a cliff after getting into difficulty while coasteering with 2 other people. He swallowed sea water while trying to get through a gully at Port Dafarch, near Trearddur Bay, Anglesey. An RAF Valley rescue helicopter took the man to hospital in Bangor. He was said to be very confused and in a "near drowning" state. One of the rescue crew said that the group were well equipped but the sea in the gully was very rough. An inspector is making enquiries to try and find out where the group were from.

q) August: An 11 year old girl was involved in an incident on a zip wire at a licensed provider. The provider reported that she had gone down the zip wire and had come to a natural stop. The instructor at the bottom of the zip told her to drop the live rope onto the ground and to undo the back up safety rope (a short length of rope which is attached to the pulley at one end and which has a karabiner attached to the other). As she started to lower herself to the ground, the karabiner managed to get stuck or clip itself under or onto the front of her helmet. This meant she was stuck and held up by the helmet rather than the live rope. The instructor supported her feet from below and called for help on the radio. The duty manager went over, untangled the safety rope and brought her to the ground. She had lost consciousness for a short period of time but recovered consciousness very quickly once on the ground. She was taken to hospital by ambulance and kept in overnight for observation. The provider advised that it appeared that the safety rope karabiner had an open gate leading to the snagging and suspension. Provider is due to update the inspector once further investigations have taken place.

<u>Incidents which occurred outside the reporting period</u>

a) August 2006: A 17 year old student was taking part in a conservation project on a remote island in Fiji which was organised by a British company. He was electrocuted when he came into contact with a metal washing line which had inadvertently come into contact with a live mains power cable after going to help a colleague who had suffered an electric shock. He died from a massive heart attack. A Fijian electrician was charged with manslaughter.
An inquest in 2008 was adjourned. At an inquest in March 2011 a verdict of unlawful killing was recorded when the coroner said that his death was so grossly negligent and it amounted to a criminal offence under English law. Other students gave evidence that no specific health and safety training was offered on arrival, nor were they told the location of any first aid equipment or standard procedure in the event of an emergency.

In July 2011 the publication Private Eye reported that business secretary Vince Cable's response to the coroner had ruled out any tightening of safety regulations. He said that since the death, the voluntary British Standard 8848 had been introduced and that consumers were strongly advised to check that providers complied with these regulations.

b) April 2007: A teacher sustained serious injuries whilst participating in a welly throwing activity. He was accompanying a school group on activities at River Dart Country Park run by a licensed provider. Whilst throwing a welly, it is thought that he fell forward onto his neck. He is thought to have broken his neck and to be paralysed from the neck down.

He is currently taking court action against the provider. AALS were contacted by the solicitor acting for the provider and a Senior Inspector has provided a witness statement.

c) March 2009: An 18 year old student died as a result of an uncontrolled fall from a bridge swing in New Zealand. She was a member of a university alpine club and was participating in an annual bridge swing event operated by a commercial provider. When she did her second jump her rope was not attached to the rig and she fell straight down into the dry river bed. She suffered severe injuries and died in hospital later that day.
An inquest in March 2011 found that she died as a result of multiple injuries sustained in a fall from height.

d) July 2009: An adult male (age unknown but over 18 years) suffered a broken femur and injuries to his scalp when he was on an activity run by a licensed provider in July 2009. The injured party advised via an e mail received on 15.07.11 that, whilst climbing out of the gorge, the instructor was belaying the group out using a body belay. He was the last member of the group. He weighted the belay rope and, due to the fact that the instructor wasn't tied on, they both fell into the gorge. They were rescued by Coniston Mountain Rescue Team. The entry on Coniston Mountain Rescue Team's website states that: "Two men fell whilst scrambling out of gorge. One seriously injured. Broke leg and suffered lacerations to head. Stretchered to safety and taken to Furness General by helicopter."

e) October 2009: A 66 year old male drowned whilst on a raft trip with a commercial company on the swollen River Dalaman in Turkey. He was knocked unconscious when the raft hit a rock and capsized, throwing 7 tourists and their guide in the water.
At an inquest in April 2011 a narrative verdict was returned. The coroner said that the guides had taken an "unreasonable risk' in proceeding with the activity. Evidence was heard that he was a non swimmer, had an ill fitting lifejacket, that some helmets didn't fit properly and that several paddle blades had pieces missing.
The 2 guides were arrested after the incident but no further information available about further action taken in Turkey.

f) May 2010: A 14 year old sea cadet, fell from a yard on the fore mast of the sail training ship TS Royalist when the vessel was at anchor. The sea cadet was assisting other cadets to stow the fore course sail when he fell backwards and struck the starboard gunwale 8m below, before falling into the sea. He was quickly recovered from the water by the vessel's sea boat and transferred to a coastguard helicopter which flew him to hospital. Sadly, the cadet died as a result of the severe injuries he had sustained.
This was the first fatality on board TS Royalist in her 39 years of service. The sea cadet fell to the deck because he unclipped his belt harness from the wire jackstay provided on the fore course yard, contrary to his training and onboard procedures for work at that position. However, the MAIB investigation report published in March 2011 highlighted concerns regarding the supervision of the cadets when aloft on the vessel's masts and rigging, and the suitability of the belt harnesses provided. Recommendations were made to the Marine Society & Sea Cadets and the Royal Navy aimed at improving the safety of cadets by addressing the safety issues identified and, through the development of assurance procedures, to ensure that the risks to cadets are reduced to and kept as low as reasonably practicable.

g) October 2010: A yacht club was hosting a residential race training event for girls aged 10 - 13 years. They were staying approx a mile across the water from the club so the girls were ferried to and from the accommodation each day in four RIBs. According to an article in Wavelength in Spring 2011, during the trip on the evening of 27/10/10, one of the RIB drivers veered too far to one side and, fearing that there was a danger of running into some unlit marks, she altered course and turned back towards her original track, colliding heavily with another RIB. Three of the sailors were thrown into the water, one of the girls was thrown from one RIB into the other and several girls suffered varying degrees of injury, including bruising, rib, spinal and head wounds. MAIB are investigating.

h) February 2011: A 14 year old school boy died after being in a coma for a week following an accident whilst on a school skiing trip to Chatel, France. It is believed that he became trapped by his backpack (or other equipment) whilst getting off a ski lift. His airway was restricted until he was rescued. He was initially airlifted to hospital in Annecy and then back to hospital in Exeter, but he never regained consciousness.
French police are investigating on behalf of HM Coroner, but a spokesperson said in March 2011 that it was not being treated as a criminal inquiry.

Marcus Bailie 31.08.11