**Adventure Activities Licensing Authority Meeting**
**Tuesday 29th March 2011**

**Adventure Activities Licensing Service Head of Inspection report**
**September 2010 – February 2011**

## 1. Number of Licence Holders

This stands at 1243 as at 28.02.11.

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, one provider was issued with a notice that we were considering revoking their licence and one that we were considering refusing their renewal application.

With regard to the case in which revocation was considered, the provider failed to provide the required information within the 28 day deadline. However, their licence had already expired. They provided the required information when they successfully applied for a renewal of their licence in February 2011.

With regard to the case in which refusal was considered, the provider addressed our concerns satisfactorily and had their licence renewed.

See Appendix 1 for more detail.

There were two cases where revocation was being considered that were still in progress during the last reporting period to August 2010. In one case no contact was received from the provider and their licence was revoked. In the second case the provider addressed our concerns and their licence continued.

## 3. Recorded Accidents and Incidents

During the reporting period, 18 accidents / incidents were entered on the Licensing Service's database. 9 of these occurred during the reporting period and 9 were entered retrospectively as information was received or records were updated.

Of the 9 cases which occurred during the reporting period, 5 involved fatalities. 1 case resulted in the death of 1 young person under the age of 18 years and 4 in the deaths of 5 adults.

Of the 9 cases which occurred prior to the reporting period and entered on to the database retrospectively, 5 involved fatalities. 1 case resulted in the death of 1 young person under the age of 18 years and 4 cases resulted in the deaths of 8 adults.

Of the 2 young people who died, 1 was taking part in a non-licensable watersports activity and 1 fell from height whilst trekking abroad with a commercial provider.

Of the 13 adults who died, 5 died in one incident involving a road traffic accident abroad and 2 in a watersports accident abroad. The other 6 were in separate incidents: 2 fell from height whilst climbing, 1 was trekking alone, 1 fell down a disused mine shaft and 1 drowned after falling off a rope swing into water.

Details of all 18 incidents are shown in Appendix 2.

## Appendix 1

1. **Minded to Refuse licence, Rescinded**

   Following receipt of a renewal application, a local authority was inspected on 13th August 2010. The Inspector was unable to complete the provider's renewal application due to concerns regarding their activity approval scheme and a lack of a strategy for ensuring that a sufficient and appropriate sample of activities is seen each year. Further information was required from the provider to address these concerns.

   Their licence expired on 10th September 2010 and they were sent a standard expiry notice confirming that they could not legally offer activities for which a licence was required.

   The Inspector visited the provider again on 14th October 2010 and found that his concerns had not been addressed.

   A Notice that we were considering refusing their licence renewal application was sent to the provider on 26th October 2010 with the requirement that they send evidence regarding the above.

   The required information was provided during a meeting in the Licensing Service's office on 16th November 2010 and the licence was renewed as from 10th September 2010.

2. **Minded to Revoke licence, Revoked**

   The provider was inspected on 11th November 2010 in advance of a renewal application being received. The Inspector identified failures in the following areas:

   - Failure to keep complete staff files for all permanent and freelance instructors and failure to ensure that they are always available.
   - Failure to have suitably experienced and qualified persons who are able to offer technical advice for all licensable land and water based activities offered.
   - Lack of clear guidance to staff on recording all accidents and incidents appropriately and informing RIDDOR where necessary.

   As a result, a Notice that we were considering revoking their licence was sent to the provider on 22nd November 2010. No information was received from the provider so a Notice that we had revoked their licence was sent to the provider on 5th January 2011.

   The provider subsequently sent in a renewal application form and enclosed the required information. The information supplied addressed the Inspector's concerns and their licence was renewed as from 8th February 2011.

**Appendix 2**

Details of the 18 accidents entered on the AALS incident data base.

Incidents which occurred during the reporting period

a) September 2010: An 11 year old girl died from severe leg injuries sustained when she apparently fell off an inflatable banana boat ride and was thrown into the propeller of the towing speedboat as it was doing a sharp turn. She was attending a children's birthday party at a water park in West London.

The driver of the towing speedboat, was arrested after the incident and bailed until October 2010.

b) September 2010: Two experienced stand up paddlers died on the Mangall River, near Munich. They had decided to go for a quick evening paddle after work on a section of river that they knew well. The river was unusually high and they were washed downstream quickly and over a low head dam. Trapped in the hydraulic at the dam's base, the two men drowned. Both were equipped with life jackets, helmets and leashes.

c) September 2010: A 31 year old experienced climber was climbing at Blacknor North, Portland, Dorset when his foot placement dislodged a large amount of rock. As it fell the rock cut the rope, causing him to fall 15 metres directly onto the path. He was pronounced dead on arrival at hospital having suffered massive internal injuries. Dorset Police described his death as a tragic accident.

A representative from the coroner's office in Blandford phoned to request assistance in inspecting the rope. An AALS Senior Inspector inspected the rope and wrote a report.

d) October 2010: Letter received regarding an incident which occurred in Derbyshire show caves. A tourist party of approx 17 people (including 3 children) plus 3 members of staff had to wade/swim 50 - 75 metres through a tunnel to exit the cave when waters rose so high that the boat was unable to get out. According to staff they had never seen the water so high.

HSE advised later in the month that no enforcement action would be taken as the flooding occurred in "unusual environmental conditions". They made a recommendation that a water level alarm system should be installed, along with communication devices and portable lights in the boat. The owners were also advised to re-examine safety procedures.

e) October 2010: A 10 year old girl broke her wrist when an autobelay device apparently failed and she fell to the ground. She was jumping from a trapeze pole to a trapeze bar whilst on an activity at a licensed centre.

The local Environmental Health Officer requested assistance in investigating the incident.

f) October 2010: A13 year old girl sustained a severe break to her left ankle when she fell 9m on an indoor climbing wall at a licensed centre. She was being belayed by another member of the group and was about to be lowered when the belayer apparently caught skin between the thumb and finger in the belay device and let go. The coach who was supervising 3 pairs of young people was unable to respond as the fall happened so quickly. She landed on her feet and fell backwards. She remained conscious throughout. She was taken to hospital by ambulance and was found to have a severe break to her left ankle (which needed pinning), bruising but no other serious injuries.

HSE requested assistance from AALS in investigating.

g) November 2010: A 51 year old male Scout leader was found dead near Beddgelert, Gwynedd by a helicopter search and rescue crew from RAF Valley, Anglesey. It was understood that he had been out walking alone and the police were called when he failed to return home. Members of the Aberglaslyn mountain rescue team were also involved in the overnight search. He was reported to be an experienced walker and mountaineer.

h) December 2010: A 54 year old climbing instructor was ice climbing on the frozen Cautley Spout waterfall in the Eastern Howgills with a friend when he slipped and fell 75' to his death. Emergency services, including local mountain and cave rescue teams, attended the scene and resuscitation was attempted by a paramedic, but he was pronounced dead at the scene. As his body was in a deep rocky gill, he had to be winched from the foot of the waterfall by a helicopter from RAF Valley.

i) January 2011: A group of 16 kayakers from a canoe club in Hampshire had to be rescued when they got into difficulties near the Race off Portland Bill. A rescue helicopter and 2 lifeboats responded to their mayday calls and rescued them all into the boats. Two of the group were airlifted to hospital, one very seasick and another with suspected hypothermia and shock. A spokesman for the Maritime and Coastguard Agency said that the group (2 leaders and 14 members) had been well equipped and had a mobile phone and radio with them but he was unsure if they were aware of the particular conditions in the Race. The group had become separated into two groups and one of the groups had been swept into the Race.
Potentially a very serious incident...

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

a) January 1977: This incident file was set up following a conversation between Marcus Bailie and someone who knew the deceased, who died in a

kayaking accident in the Black Mountains area in 1977/78. A search has been carried out on the internet but no reference to the incident has been found. The date 1/1/1977 is nominal for 1977/1978.

b) July 2005: A school in Hull took a group of 14/15 year old pupils on an end of term trip to a country park as a PE lesson. The group was split into 2 teams to play a game which involved spotting members of the opposite team in order to eliminate them from the game. Unbeknown to the staff a few of the pupils walked up to the top of a chalk quarry which forms the country park in order to get a better view. One of them slipped and fell 60-80', landing in the wooded area below. He sustained two spinal fractures, two fractured ribs and a fractured wrist but it is believed that he has since made a full recovery.

The HSE investigating officer requested assistance from AALS, specifically whether this was a suitable activity and whether the pupils were adequately supervised.

c) June 2007: A PE teacher fell and broke both her legs when she fell from a high ropes course. The incident happened at the end of a cow's tail high ropes course at a licensed outdoor centre when the instructor unclipped her from the cow's tail but failed to attach her to the safety rope before she jumped for the trapeze.

HSE requested assistance from AALS with the investigation.

d) April 2008: Five British women taking part in a 15-week South American adventure trip died in a bus crash as they travelled between the Ecuadorian capital, Quito, and the small Pacific-coast village of Puerto López. They were killed when their bus was struck by a speeding truck driving on the wrong side of the road. The left side of the bus bore the impact and at least some of the five victims were thought to have been killed instantly. Other passengers were treated for whiplash and minor facial and leg injuries.

e) July 2008: A 44 year old female fell 60' down a disused mine shaft when she took a short cut home after a night out. Her daughter heard her cries for help and alerted the emergency services. She died after suffering a heart attack just as she was brought to the surface by the Strathclyde Police mountain rescue team six hours later. The fire service did not bring her to the surface because a memo had been issued 4 months earlier forbidding firefighters from using lifting equipment on members of the public.
A Fatal Accident Inquiry (FAI) was held in March 2010 and adjourned at the end of that month after all evidence had been heard. Medical evidence given was that she died from a combination of hypothermia and chest injury but that these were survivable. In May 2010 it was announced that the FAI was to be re-opened to hear new evidence. In August 2010 the FAI was re-opened with evidence heard from a retired fire officer. In October 2010 the FAI was re-opened for the second time after the Scottish Cave Rescue organisation asked to give evidence, having not been asked to attend the previous 2 hearings. The leader of the cave rescue organisation had written to the Sheriff and claimed that they could have rescued the victim from the shaft quickly on the night but

that they were not contacted, despite being part of the 999 emergency service.

f) June 2009: A serious accident occurred involving a student on an organised outdoor activity at a licensed centre. The student fell a significant distance and suffered spinal injuries, even though she was wearing a harness and her fall should have been arrested by a belaying arrangement.
Investigations found that a Petzl gri gri was being used as a belay device and that the student who should have been operating it had put it down and walked away. The gri gri was attached close to the ground.
HSE requested assistance in investigating the incident.

g) July 2009: A17 year old male fell nearly 1000' to his death in the Picos de Europa region in northern Spain. He was travelling with 6 other young people and 3 leaders on an expedition organised by a commercial company and they were camping next to a mountain refuge at Collado Jermoso. It is believed that he fell from steep ground when he had gone off on his own to find somewhere to go to the toilet. He was already dead by the time police mountain rescuers arrived and found his body.
At an inquest in May 2010 a verdict of accidental death was reached. The coroner said that a risk assessment of the area and ensuing instructions to the group had not been detailed enough.
The trip had originally failed to get approval from the Young Explorers Trust because it did not have leaders with the right qualifications and concerns with familiarity with the location. It was later approved after an experienced leader joined the group. The expedition was equipped with a small scale map and a 2003 Lonely Planet guidebook.

h) April 2010: A 32 year old male was in a group of 21 university students (all over 18 years) on a walk in the waterfalls area of Ystradfelte, South Wales. They were in the area known as the 'Blue Pool'. Six of the group swung out on the rope swing. After lunch he also tried and possibly slipped from the rope, ending up in the water. He struggled in the water and friends went to help him but without success. There was also a group from a licensed provider in the area and their lead instructor was called to assist by a member of the university group. She performed CPR but there were no vital signs. He died at the scene and his body was taken to Morriston Hospital, Swansea by the rescue helicopter.
Primary cause of death was found to be drowning. There was a lot of food found in the lungs so it would have been difficult to resuscitate him.
The ambulance took approx 1 hour to arrive. There was an issue with incorrect grid references and members of the Brecon Mountain Rescue Team initially went to the wrong venue.
Cause of death was found to be 1)drowning and 2)aspiration of gastric contents.
At an inquest in October 2010 a verdict of accidental death was reached.

i) 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. He sustained

fractures to his back, ankle and arm and as at January 2011 is still in hospital. An EHO from Tonbridge and Morling Council contacted AALS in January 2011 to ask for our assistance, particularly whether anything could/should have been done differently to ensure his safety. Advice also requested on parafan descenders.

Marcus Bailie 21.03.11