The Mangatepopo Incident

April 2008

**Information** on the incident can be found at [www.opc.org.nz/mangatepopo.php](http://www.opc.org.nz/mangatepopo.php), particularly the coroner’s recommendations and the responses from the Sir Edmund Hillary Outdoor Pursuits Centre (OPC).

**Discussion** of the incident can be found in the *NZOIA Quarterly*, Issue 54.

Most OPC responses relate specifically to Mangatepopo Gorge trips. However, they raise wider issues such as those outlined below.

### Does the activity relate to educational objectives?

Although the Mangatepopo Gorge trip may have been driven by educational objectives, a commitment to a ‘water day’ and the instructor’s lack of known options may have been contributing factors to the incident.

The implication is that outdoor leaders need to know the venues and activities that will enable them to achieve their educational objectives, and which ones are appropriate in different circumstances.

### Are staff adequately trained?

The health and safety legislation requires staff to be adequately trained or supervised by someone who is. Presumably, the test is whether staff competencies match accepted best practice. The competencies required are indicated by NZOIA, MSC, EONZ, Skills Active, Surf lifesaving, Swimming NZ and other syllabuses, although standards require external benchmarking.

There’s debate as to whether focusing on a systematic approach is faulty, and whether the focus should be on employing highly competent staff. It may be more helpful to regard recruiting, inducting, training, and monitoring staff as one part of a systematic approach, possibly the key part.

Since the incident, Department of Labour (DOL) prompting has brought a focus on monitoring, primarily to check that policies and procedures are being implemented.

### Is the supervisory structure adequate?

The accompanying teacher wasn’t trained to take a leadership role in the gorge, making the leader to participant ratio 1:11. Given the environmental hazards, the instructor’s inexperience, and the nature of the participants (some under stress, some non-swimmers, and one with a partial disability), this ratio appears unsuitable.

Counting accompanying adults (especially teachers and parents) as leaders, irrespective of their training and experience, may often occur in outdoor education. The implication is that each person must be assessed as a leader or a participant before determining the ratio.

### Are the roles and responsibilities clear?

DOL argued that the OPC Field Manager should have closed the gorge, that is, the decision to enter the gorge or not shouldn’t have been left to the instructor.

The implication is that a ‘command model’ is most effective. Given the manager’s access to updated weather information, that may have been the case in this situation. However, it wasn’t OPC’s policy for the manager to sanction trips, and staff in the field will often have the best information to make decisions. OPC’s review noted it would have been very difficult to ‘…micromanage instructors in the field by remote control’.

It does point to organisations being clear around who makes decisions. Because there’s uncertainty around the exact nature of a discussion between the OPC manager and the instructor, it also illustrates the need to communicate clearly.

### Are the weather forecasts sufficiently detailed and up to date?

OPC was criticised for not subscribing to a more detailed weather forecast (the MetService’s severe weather warning alerts). How widely applicable this issue is will depend on the vulnerability of each activity to the weather, but it does point to accepted best practice requiring more information than was sought in the past.

Similarly, venturing into the snow without an avalanche advisory or onto the sea without a marine weather forecast isn’t accepted best practice.

Also, although OPC received a forecast at 6.15am, that forecast was compiled at 1.18am. Part of it was read to instructors at 8.00am. The group entered the gorge at about 12.30pm, raising the issue of what updated weather information should an activity leader access.

### Is the water level rising or falling?

It’s accepted best practice to set a maximum river flow level for an activity. The incident points to the need to know more than this – the instructor needed to know whether the river was rising or falling.

Obviously, this applies to a range of activities, not just canyoning.

### Are the communications adequate?

Accepted best practice is that a group must be able to communicate immediately where practicable. The coroner suggested that if communications weren’t possible, then minors shouldn’t be taken on the activity.

However, communications aren’t practicable for caving, or for many other activities at times. Accepted best practice is to map ‘dead zones’ and to mirror the aviation practice of communicating with the base when entering and leaving such zones.

### Does the safety planning focus on significant hazards?

OPC hadn’t fully identified the hazards associated with an upstream gorge trip despite having detailed planning documents. Lengthy paperwork (including detailed risk management forms) can obscure which hazards are the most significant.

### What practicable steps weren’t taken?

Although the health and safety legislation requires employers to take all practicable steps, it doesn’t prescribe those steps. When there’s a fatality, analysis will likely reveal some practicable steps that could have been taken. The Department of Labour first charged OPC with 18 omissions, which they reduced to these two:

1. OPC didn’t obtain adequate weather information.

2. OPC didn’t close the upstream gorge.

When staff have become comfortable with an environment, external audits or peer reviews may notice omissions, although they didn’t in this case.

### Is there learning from previous incidents?

Although OPC often changed its policies after incidents, and regularly reviewed incidents, it didn’t fully build the learnings into the induction of new instructors.

Potentially, this applies to all organisations. Shared learnings from use of the National Incident Database could be especially powerful.

### Who has final responsibility?

The focus of the court hearings was on OPC’s responsibilities as an employer. OPC was prosecuted for breaching its duty of care to an inexperienced employee. The DOL informed the school that it had met its legal requirements and wouldn’t be prosecuted.

However, schools do have final responsibility for their students, whether they run the programme themselves or contract an outside provider – see *EOTC Guidelines: Bringing the Curriculum Alive*, particularly paragraphs 193–194, 210, and 171.