Workshop Two

EOTC Guidelines   
Bringing the Curriculum Alive

Participant’s Workbook

September 2012, Edition 2

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| **An EONZ-NZAEE-MSC project funded by Sport NZ** | | | | |





The EOTC Guidelines writing group drafted this over-view for a systems approach in response to participant feedback from the PL &D workshops 2011-12. It provides one model for schools to use and adapt as a summary of ‘a systems approach’ as advocated in the EOTC Guidelines: Bringing the Curriculum Alive. Further discussion and comment is welcome on the EONZ (Education Outdoors NZ) Facebook site.

**TKI EOTC Sitemap**

* [**EOTC home**](http://eotc.tki.org.nz/EOTC-home) **http://eotc.tki.org.nz/EOTC-home**
  + [For teachers](http://eotc.tki.org.nz/EOTC-home/For-teachers)
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      * EOTC in action -NEW
      * Making EOTC happen -NEW
      * Activities, Ideas, Tools -NEW
      * Learning Safely -NEW
    - [FAQ](http://eotc.tki.org.nz/EOTC-home/For-teachers/FAQ)
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    - [Tool Kit](http://eotc.tki.org.nz/EOTC-home/EOTC-Guidelines/Tool-Kit)
  + [Learning voices](http://eotc.tki.org.nz/EOTC-home/Learning-voices)
    - [Coley Street School](http://eotc.tki.org.nz/EOTC-home/Learning-voices/Coley-Street-School)
    - [Newton Central School](http://eotc.tki.org.nz/EOTC-home/Learning-voices/Newton-Central-School)
    - [Twizel Area School](http://eotc.tki.org.nz/EOTC-home/Learning-voices/Twizel-Area-School)
    - [TKKM o Rotoiti](http://eotc.tki.org.nz/EOTC-home/Learning-voices/TKKM-o-Rotoiti)

**EONZ on Facebook**

A way of sharing ideas, resources or issues.

Search Education Outdoors New Zealand on Facebook

or use the link on EONZ website ([www.eonz.org.nz](http://www.eonz.org.nz))

or on the TKI ‘Making connections’ page.

**Learning inquiry – what happened for the students?**

Consider **one of your most recent EOTC experiences**

* *What are some examples of evidence to show your learning outcomes were achieved?*

Describe the evidence you have to determine what happened for the students and whether this achieved the students’ desired learning outcomes.

Looks like

Feels like

Sounds like

**Roles and Responsibilities**

Reflecting on your current practice in your organisation, are people allocated to roles in a way that met the needs of your EOTC programme?

|  |  |
| --- | --- |
| |  | | --- | | Do you understand your role? How do you feel about it? | |
| In your organisation does your system have someone in each of the roles recommended in Chapter 2? If not, how are the responsibilities shared? |
| Do some people have more than one role? If so, how does this work? |
| Do roles change depending on the EOTC experience? For example, is an EOTC co-ordinator sometimes an assistant? |
| Do people in your school holding these roles have the required competency? Are their competencies current?  How is this determined and recorded? |
| Does your organisation provide PLD for people in those roles? How is this determined and recorded? |
| How does this get reviewed? |

**What roles and responsibilities can you identify?**

**Primary case study**

A year 5 and 6 class of 32 students engaged in a LEOTC programme on early settlers of the local area. The key experience for the day was to re-walk the pathway that early arrivals to the region would have taken up over the hill to the new settlement. The walk starts in an urban area walking along the roads for 10 minutes before climbing up a relatively steep four -wheel drive track. The LEOTC educator was the activity leader and had scheduled stops to tell stories and lead short activities.

The TIC had organised 7 parent/adult assistants to supervise the students but didn’t directly supervise a group themselves. The LEOTC provider had provided a SAPS/ RAMS template largely completed. 1 extra adult was present who was observing the LEOTC programme and had no connection to the school. Students were allocated to walk with parents in small groups. During the walk one of the parents struggled to keep up with the group and needed to stop regularly and vomited several times. She was also an asthmatic and shared the inhaler with her daughter who was also walking. The mother made her own way up the path and the students were re-distributed across the other assistants. The daughter continued with the group but then did not have her inhaler.

Another student was allergic to wasp stings and during the lunch stop a number of wasps ‘arrived’ on the scene. The child was not stung but did become agitated. The student had an adrenalin kit in their bag but it had not been checked prior to coming on the trip.

One adult assistant (one of the seven) was the teacher aide for a student with high learning needs for behaviour.

**What roles and responsibilities can you identify?**

**Secondary case study**

A Year 12 multi day PE camp in Leadership and Safety Management. There were 33 students, 4 teachers, an outdoor educator (contractor) and a cook (Scout leader, truancy officer) who is an experienced tramper and kayaker. In addition there were outside instructors contracted for the kayaking and caving experiences.

The cook assisted by students was responsible for all the catering. TIC has over 10 years teaching experience and regularly leads on outdoor education camps, is a senior member of staff at the school and has considerable experience with assessment.

The 2 PE teachers of the students involved are PRTs, one first year, one second year. The second year teacher was in charge of the programme and assessment. The 4th teacher is a year 4 teacher in social sciences with experience leading on field experiences and outdoor education camps – is a keen tramper and experienced in assessment. Outdoor Educator has run this event for past 4 years and has over 25 years experience leading outdoor education experiences and school assessment processes. Students were the activity leaders and had received a training day plus classroom preparation for their role. At camp the 4 teachers were responsible for sharing supervision of students. Four groups operated for each activity during the four days – caving, mountain biking, kayaking and tramping. On each day only one activity was done by all four groups. Two students led each activity for their peers (one student led on their own for mountain biking) and had either one experienced staff member or two staff accompanying them depending on the activity and the staff members’ skills.

Mountain biking and tramping were overseen by school staff. Lake Kayaking and caving were overseen by outside instructors assisted by school staff.

In all circumstances

* a group no larger than 7 students had at least one competent adult leader
* a PRT was not in sole charge of a group
* a student leader was being assessed by at least one experienced assessor.

NOTE:

In making a decision on competent staff and their deployment for a Y12 PE multiday outdoor pursuits camp including the assessment of Leadership and Risk Management achievement standards; the TIC made initial recommendations, a senior manager had responsibility for approving staffing, decided too many staff were involved and hence approved a lower level of staffing than required. This was successfully challenged by the TIC and the required leadership and supervision deployment occurred.

The Senior manager did not have sufficient understanding of the event’s requirements (ie the required competence to make the decision). For example the number and competence of assessors required to ensure fair student assessment. Also the students’ course teachers, while very capable, were inexperienced PRTs and hence needed to be supported by experienced staff.

Severity scales and ratings

**Severity rating**: Select both the actual and potential severity for the incident. Use the

incident severity scale to rate the severity of the incident.

o **How to rate an incident**.

The key severity rating factor is the “**impact on participation**” column. Do not use the examples in the injury column as the sole judgment of severity. For example, blisters are listed as a severity ranking of 3, but if a participant can no longer participate in a tramp or sea kayak journey for a couple of days, then this could rise to a severity ranking of 4. Conversely if a participant had blisters on their feet or hands, but could still walk or paddle then this would **not** be considered an incident as they can still participate in the activity. If it is an equipment or environmental incident then use those descriptors. If the incident is a near miss, rate the actual severity, then rate the potential severity.

o **The importance and usefulness of recording both the actual and potential severity rating of each incident**

A person on a tramp falls 5m down a bank and sprains their ankle. They have to be evacuated. This incident would rate a severity of 4-5, but in this instance if they had fallen 1m further they would have gone over a 20m bluff, therefore the potential severity was a 9 (potential fatality). The high potential severity would warrant further investigation and consideration as to minimising/reducing/eliminating the risk in this area, whereas recording only the actual severity may not have highlighted the near miss. Severity ratings allow you to focus on the incidents that had high actual or potential severity and put processes in place to prevent future reoccurrence.

Downloaded from <http://www.incidentreport.org.nz/resources/OER_NID_Guide.pdf>

Why record near misses

“Near misses” or “close calls” with high potential for serious harm should be investigated as thoroughly as incidents that result in serious injury. Near miss incidents have been shown to have similar causes to serious incidents, yet are grossly under-reported and are often “shrouded by a veil of silence”. They differ from serious incidents in that no injury or damage results. But the types and degree of loss are often a matter of chance, depending partly on luck and partly on the actions taken to minimise the loss. Consequently, the effect could range from insignificant to catastrophic, from a scratch or dent to multiple fatalities or loss of plant (equipment or buildings).

Some important indices of close calls:

* People involved express relief, often through exaggeration and humour,
* They often do not identify it as a true incident so do not report it formally,
* Therefore no analysis is made,
* No analysis means no interventions to stop or alter the close-call circumstances are made, which means the close call is likely to occur again.

Taken from Haddock, C. (2005) *Outdoor safety: Risk management for outdoor leaders (2nd ed.).* Wellington: New Zealand Mountain Safety Council (pp. 74-75)

Serious harm and near misses

|  |  |
| --- | --- |
| INCIDENT | What is the severity? (See severity scale)  What do you think the severity could have been? (ie the potential severity)  Which are the near misses?  What action is required in terms of reporting? |
| Paper dart strikes a student in the face close to her eye (no actual damage). |  |
| Broken femur while tramping. |  |
| Verbal statement that student intends cutting himself. |  |
| Sprained ankle while tramping. |  |
| While inside a staff member falls from table onto floor and says ‘I am ok’. |  |
| Mini bus door flies open while being driven in city.  Student immediately beside the door is not wearing seat belt and is grabbed by another student. |  |
| Student biking back from hut loses control, goes over the handlebars resulting in bruises and grazes. He is confused, shocked, winded.  Instructor at the front didn’t see incident. |  |

**Stages in the incident recording, reporting and reviewing process**

**Two examples from a NID generated table**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Activity** | **Incident/**  **Description** | **Causal**  **Leader/ Participants/**  **Equipment** | **Severity**  **(Actual)** | **Severity**  **(Potential)** | **Recommendation/ Outcome** |
|  | Abseiling | Instructor in sun for day. Went to get a drink. His safety line was too short so he unclipped before going back and began to bring student down to him to abseil. He realised and re-clipped himself in. | Judgement error  Inadequate design | 0 | 9 | Stay focused / in attention and need to check. Take proper break if needed for concentration level.  Possibly add to the safety length – look in to. |
|  | Tramping | Student tripped while walking down steep area. Twisted L ankle. Able to continue | Uneven ground, footwear | 3 | 5 | Uneven ground with some slippery roots caused the student to slip. Good briefing and control. Check footwear. |

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| **Key Messages for you** | **Notes** | **Planned actions** |
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# Follow-up action plan

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| **Planned action** | **Who** | **When** | **Done date** | **Outcomes / next steps** |
| Our school can strengthened our systems by… |  |  |  |  |

# Links

|  |  |
| --- | --- |
| **Topic** | **Website** |
| Education Outdoors NZ (EONZ) | www.eonz.org.nz |
| NZ Association for Environmental Education (NZAEE) | www.nzaee.org.nz |
| NZ Mountain Safety Council (MSC) | www.mountainsafety.org.nz |
| *EOTC Guidelines: Bringing the Curriculum Alive* | http://eotc.tki.org.nz/EOTC-home/EOTC-Guidelines |
| Key competencies. | [http://keycompetencies.tki.org.nz](http://keycompetencies.tki.org.nz/) |
| Learning Experiences Outside The Classroom (LEOTC) | <http://eotc.tki.org.nz/LEOTC-home> |
| EOTC Community (MOE) | http://eotc.tki.org.nz |
| NZ Trustees Association (NZSTA) | www.nzsta.org.nz |
| *OutdoorsMark* audit tool | www.outdoorsnz.org.nz/cms\_display |
| *Outdoor Activities: Guidelines for Leaders* (2009)  (Outdoors NZ holds the hard copies) | [www.sparc.org.nz/en-nz/young-people/Guidelines--Resources/Outdoor-Activities---Guidelines-for-Leaders](http://www.sparc.org.nz/en-nz/young-people/Guidelines--Resources/Outdoor-Activities---Guidelines-for-Leaders/) |
| NZ Outdoor Instructors Association (NZOIA) | www.nzoia.org.nz |
| Skills Active | www.skillsactive.org.nz |
| Department of Conservation (DOC) codes of practice / access | [www.doc.govt.nz/parks-and-recreation/plan-and-prepare/care-codes](http://www.doc.govt.nz/parks-and-recreation/plan-and-prepare/care-codes/) |
| NZ Access Code | [www.walkingaccess.govt.nz/store/doc](http://www.walkingaccess.govt.nz/store/doc) |
| National Incident Database (NID) | [www.incidentreport.org.nz](http://www.incidentreport.org.nz) |