ANDERSONLLOYD
LAWYERS

Coroner's Report Released Regarding Mangatepopo Stream Tragedy on 15 April 2008

The Coroner has made extensive recommendations following the death of a teacher and six students at the Mangatepopo Stream, Tongariro on 15 April 2008. The tragedy occurred while they were participating in a gorge trip as part of an outdoor programme conducted by the Sir Edmund Hillary Outdoor Pursuits Centre (OPC).

OPC had previously pleaded guilty to two charges under the Health & Safety in Employment Act and was sentenced in March 2009 to pay $60,000 to the family of each victim, $5000 each to the survivors and fined $20,000 on each charge. The total financial penalty was $460,000.

The Incident

Sir Edmund Hillary Outdoor Pursuits Centre of New Zealand (OPC) led a group of ten students and one teacher from the Elim Christian College at Auckland on a trip up a lower gorge of the Mangatepopo Stream. When they commenced the trip the stream flow was low. By the time the attempted to exit the gorge at approximately 4.00pm the stream was a raging torrent. The teacher and six students died. The instructor and three students survived.

OPC is a charitable trust which operates an outdoor pursuit centre from which it conducts outdoor education and training programmes, especially for secondary schools, with programmes tailored to the experience of groups.

Recommendations

A summary of the Coroner's recommendations specific to OPC is below:

- The provision of better information regarding the Mangatepopo stream to OPC staff.
- OPC staff undertaking gorge trips to be fully trained, including in assessing water levels.
- Better communication between OPC staff, with the Field Manager having overall responsibility as to whether a trip should take place.
- Instructors to provide the Field Manager with a time plan for each trip.
- Monitoring of rainfall prior to trips and a conservative approach taken as to whether trips should proceed.
- Radio communication between OPC and instructors in the gorge.
- 2 instructors on each trip, both carrying waterproof radios with earpieces.
- Fallback method of communication if radio communication fails.
- Accompanying adults to be made aware of exit points, safety position and how to use communication devices.
- Policy put in place to exit immediately when a rise in water level is observed.
- A written rescue plan developed and rescue exercises undertaken.

The Coroner also made the following wider recommendations to prevent similar incidents elsewhere:

- That the Government consider the licensing of outdoor education/adventure operations which provide activities to persons under 18 years of age to ensure minimum standards are met.
- Emphasis be given to the public and in particular training institutions, including polytechnics, that the linking of individuals swimming or floating in moving water is potentially dangerous.
- MetService to include severe weather warnings in applicable regional forecasts.
- MetService to issue written forecasts with the time of the preparation of the forecast clearly displayed.
- MetService to review its procedures around follow up communications to forecast recipients when there is an error in a forecast.
- Outdoors New Zealand to review its policies and procedures around OutdoorsMark safety audits and training provided to its auditors.

General Comments

The Coroner commented that an element of risk in outdoor activities was appropriate and that safety in outdoor adventure can never be 100% guaranteed. However proper risk identification and management is vital to avoid serious injury and death. In the Mangetepopo gorge this requires an awareness of the environment, identification of hazards, proper assessment of the likelihood of adverse events occurring and plans for when these occur. In this case the following factors contributed to the deaths:

- Lack of environmental awareness
- Lack of instructional use of historical information
- Instruction inexperience
- Lack of proper assessment before entering the gorge regarding water levels
- Lack of/inadequate communication between the instructor and Field Manager/ base staff
- Failure to implement a crisis plan and dispatch response teams in a timely manner
- Under-estimation of risks and complacency.

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