CASE 2
Lessons learned when 'rafted' canoeing goes wrong

Lessons Learned Group

Narrative

A group of middle managers were on a team-building exercise which included an open water journey of about one-and-a-half miles (close to but not across a deep tidal shipping channel) in two open canoes, rafted together with spars. There were two instructors and a facilitator in a small rescue boat accompanying them.

Weather conditions deteriorated and the wind picked up to Force 5. The group was making such little headway in the choppy conditions that the decision was taken to tow the raft with the rescue boat. Whist under tow the rafted canoes began to take on water, bailing was too little and too late, and problems with the towing arrangement resulted in the raft yawing violently, swamping it, and putting all eight team members into the water. Although only in neck-deep water at the time they were over 250m metres from the shore.

The instructor remained confident that he could recover the situation. He contacted the centre by mobile phone, and they dispatched two other rescue boats to the scene, but these boats had a seven-mile journey to reach the incident location.

The attempt to untie and empty the rafted canoes failed. Attempts to get everyone out of the water and aboard the four-man rescue boat resulted in it too swamping as the craft drifted ever closer to the shipping channel. The incident was spotted by a passing supply boat which came directly to the rescue.

Although no-one was seriously hurt; the entire episode was investigated by the Marine Accident Investigation Branch (MAIB) as a near miss.

The Lessons

Lessons Learned.

The accident chain is a series of steps, the trick is to spot the early ones:

1. Single canoes can tilt with the wave action; rafted canoes cannot, rendering them **more** likely to swamping, rather than less. Once swamped the craft is unlikely to be functional and is prone to sink. Groups and Instructors need to be ready for this. Instructors need to be practised in appropriate towing and rescue arrangements.
2. The 'facilitator' from a management training organisation, and the activity centre staff providing the boats were unclear who was 'in charge' of the session, and this tends to obstruct effective decision making.
3. The decision to continue with the exercise in the face of deteriorating conditions was influenced by (amongst other things):
   a) A perception, (by everyone concerned) that completing the exercise was all important.
   b) The lack, in the management training written brief, of any contingency plan for adverse weather, sea conditions, or other problems. Such contingency planning (i.e. having an Escape Plan) is a central part of both good business management and good risk management, and an be included in the brief without diminishing its educational or training value. Unplanned things happen in the business world too!
4. The rescue boat was too small for 11 people which suggests that an "all-in" rescue in deep water was not regarded as a serious possibility. Rescue efforts would be seriously hampered by this.
5. MAIB were highly critical that self-rescue continued when contacting the emergency services to initiate external rescue had clearly become the sensible option.
6. The root cause of most of these stages in the accident chain turned out to be the fact that the centre had not considered the possibility of such an incident developing, and therefore had not tried and refined the towing, rescue or ultimate recovery of the group. ■

The Lessons Learned Group (LLG) is a small group of professionals and enthusiasts in adventure activities, brought together by a common aim to incorporate any lessons that can be learned from accidents into ongoing good practice.

Our intention is to present an objective summary of an incident together with possible lessons. We do not aim to allocate blame or responsibility and our report represents the views of the individual members of LLG and not of any official body.

Information not currently available to us may render our comments inaccurate and the lessons identified may or may not have influenced the actual outcome. Any report published has been agreed by at least four individuals within the Group as meeting these aims.

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