Lessons learned from Stainforth Beck?

The article below is written by Marcus Bailie, Head of Inspection for the Adventure Activity Licensing Authority. The Authority has no statutory remit to comment on the matters contained in the article. Hence what follows is Marcus' personal viewpoint rather than that of the Authority. Nevertheless the Authority shares Marcus' concern at the length of time currently taken to disseminate knowledge of the lessons to be learned from previous tragedies both to those delivering similar activities and the public at large. It thus welcomes his initiative in developing a concept to address this problem."
Sir Brooke Boothby, Chairman, The Adventure Activities Licensing Authority.

The background.

It is now over two and a half years since two young schoolgirls were swept away by a stream whilst 'river walking' near the village of Stainforth, in Yorkshire. They were taking part in an annual visit with their school. Part of the programme of activities included a River Walk, an activity which the school had been doing on similar annual visits to the area for many years, and involved following the water course of a local and usually gentle 'beck'.

On this occasion however, tragedy struck. The river started to rise and by the time it had reached an obviously dangerous level the two girls had been swept to their deaths. A year later an inquest in Harrogate finally recorded a verdict of accidental death. Most people, however, still do not know what happened on that fateful day, nor what lessons we can take away to try to prevent a similar occurrence.

As is now common, the accident was investigated extensively by both the Police and the Health and Safety Executive. The evidence presented here was discussed at length in open court at the inquest, which I attended. Although this puts it in the public domain, no proper discussion of the lessons which need to be learned has so far appeared in public.

Hundreds of thousands of similar children are taken on similar visits with similar schools every year, and returned safely to their parents; their lives unquestionably enhanced by the experience. There are 7 – 10 million pupil/days of out-of-school activities every year, and if we are to prevent a similar tragedy there are a great many people who need to know why that day in Yorkshire went so badly wrong.

The process

Investigations are carried out in a variety of forms, both internally by the employer and externally by other agencies. They generally focus on three basic issues:

1. Was the accident foreseeable?
2. If it was, why was it not prevented?
3. If it was not, does hindsight now help us to understand how a similar accident could be prevented in the future?

The Coroner's Court determines, amongst other things, the first and the second of these. In this case the jury determined that the death was not foreseeable and so their verdict could only be accidental death. In other words no one was to blame. So why, one might ask, was that not the end of it?

The delays

1. Future legal proceedings

   Although the inquest was concluded, other investigations which may result in legal proceedings had not, and the perceived impact of the rules of sub-judice contributed to the delay. These mean that discussion of the issues arising from this case is inhibited in case such discussion has a prejudicial effect on any future legal action e.g. by the H.S.E, or the families of two children.

   In an investigation this thorough it is not surprising that at least some deficiencies were found with the way Leeds LEA did things. Arguably one would find at least some deficiencies if **any** large organisation is subjected to an investigation of this rigour.

   My understanding of the Coroner's verdict of Accidental Death is that the jury were of the collective opinion that the deaths of the girls had not been caused by these deficiencies.

2. The need for someone to blame.

   It would be quite inappropriate for me, from my position of detachment, to elaborate on the rights or wrongs of this. It was not my child. Nevertheless the right of parents to pursue private litigation inevitably adds to delays in making public the details of the incident.

3. Dirty laundry.

   There is a difference between being secretive and being reluctant for the details of an accident to appear in dribs and drabs, some portrayed accurately, some not. Moreover, it is difficult to have a balanced, open and fair discussion when you know that in the wings are some people eagerly waiting to sue you, and to use your comments for their own purposes. Tabloid conclusions; conspiracy theories; where will the axe will fall? Leeds LEA were in an understandably difficult dilemma.

The role of the outdoors in education

Many people wondered why teachers who were employed principally to teach classroom subjects should be leading a river-walk. The explanation is that we expect our children to grow up with certain non-academic characteristics, yet seldom question where within their education these qualities are developed? Where **do** children learn to cope with the pressures, hazards and interactions of modern living?

If we agree with many educators that standards of self-esteem, of self-confidence, of fitness and health need to be placed along side standards of numeracy and literacy then it is easier to see why school residentials and an involvement in adventure activities are widely recognised as an important and memorable part of every child's education.

The circumstances

In the moments following the two girls being swept away the two teachers appear to have acted in an exemplary fashion, and at times heroically. Had they not done so it is clear that other lives may have been lost; others were certainly in imminent danger.

The Coroner's court was told that the two teachers unquestionably made an error of judgement by stepping into the stream that day. The question was then asked: how might they have known that it was more dangerous than it looked, and could someone have taught them how to recognise this and so avoid the fateful mistake? Even professionals with substantially more experience still underestimate the power of water at times.

The local authority had no guidelines for river walking. However, the court concluded that the school had in place appropriate strategies for selecting suitable staff for the activity and inducting them by means of having a less experienced person accompanying a more experienced person over a number of years. Some of the school's practices may, therefore, have been followed more out of tradition than as a result of someone doing a formal written risk assessment but the court accepted that the outcomes were the same; it all seemed to 'stack up' properly.

Contributory factors

The court heard how there was not just one but many contributory factors. It was the unpredictable nature of this cocktail which proved to be lethal. This is commonly the case in accidents of this type, and so consequently there are often many lessons we can learn.

The Lessons

The following conclusions are my own. I believe they are consistent with the known facts of the case. Moreover they are plausible, in that they are consistent with what I see happening elsewhere. Finally, if these lessons are learned and acted upon it may prevent a similar tragedy. Most importantly none of the conclusions are unique to Stainforth Beck or to this incident. However, I can not rule out the possibility that others may subsequently reach different conclusions.

1. Moving water is frequently much more powerful then we think. Sometimes the oldest lessons remain the most poignant.

   There had been two groups in the beck that day, one in the morning and one in the afternoon. The teachers and children in **both** groups reported being surprised at the power of the water.

   There was no evidence of a cavalier attitude, nor of coercion. Those who did not want to go in the water were walking alongside on the bank. Even when some of those in the water were knocked off their feet by the water in **each** group the children still thought it was all part of the fun.

2. It is important also to recognise that water courses can change substantially, rapidly and unpredictably. The same respect which we have for mountains should apply equally to water courses.

   In the hills which form the catchment area for Stainforth Beck, lie underground caverns which act like reservoirs. In periods of high rainfall these gradually fill up, and when they are full the rush of water which is the rainstorm overflows. The court heard how this beck is therefore prone to rapid and irregular fluctuations in level over a time scale of only a couple of minutes. The various accounts in court contained inconsistencies about the water level leading to the belief that such fluctuations may very well have been active on the day.

   In either event, neither teacher had experienced conditions quite like those which they discovered on the day.

3. It’s hard to beat local knowledge, and if you don’t have it you should seek it out. It is so easy to think that conducting an activity once a year for seven years is seven year’s of experience. Its not: it’s seven days.

   The school had been conducting these same activities at the same venues for many years. Had they encountered these conditions before it is likely that they would have rethought the activity. Whilst they had not seen the beck like this others had.

This particular lesson is clear: if you don't use a venue often talk to someone who does.

4. The phrase 'clear lines of responsibility' is often thought of as a managerial process only. This is not the case. Knowing who is in charge of an activity session is equally important.

   The teacher who was to have led the river walk became ill, and two substitutes were found. One had led a number of similar river walks but not in Stainforth Beck. The other had been in Stainforth Beck on a number of occasions, but never as leader.

   There are however inherent practical weaknesses with joint leadership. For example, **each** leader may harbour almost subconscious anxieties about the unfolding events but take confidence from the apparent confidence of the other. These anxieties, if borne alone, may have led a sole leader to abandon the venture.

5. Every session should have a Plan B, even if it is only in the back of the mind of the leader. It should be thought through in advance and the group forewarned. This makes the decision on the day one of "should we do the beck or should we go for Plan B", rather than "should we do the beck or should we just go home?"

   No-one seems to have considered what to do if for any reason the activity proved not to be possible. There appears to have been no planned alternative.

6. No-one likes reporting that they have had a 'near-miss' (or a 'near-accident' as perhaps we should be calling it), yet learning from near-accidents is one of the most effective ways we have of preventing a similar but actual accident.

   The morning group had experienced similar problems with the strength of the water, and at least one of their group was briefly swept off his feet and carried by the current for a few yards. However, although the group were from the same school, and taking part in a parallel residential, they were staying in different accommodation some miles apart, were operating as separate units, and were not in communication with each other. Consequently, the experiences of the morning group were never conveyed to the afternoon group.

7. Monitoring. Getting out there and seeing what is actually happening. If I was to reduce safety in the outdoors to just two functions they would be monitoring, and using this to identify further training needs. Many employers across Britain do not do this, or do not do it as much as they should. Many

rely on some kind of paper trail, but this can never be as effective. Indeed, following the Inquest the Coroner wrote, in connection with this case, "….paperwork is an agent to, and can never be a substitute for, pro-active approaches to training and monitoring".

However, monitoring is often confused with duplication; with scrutinisers double-checking that each step has been done correctly. In fact, it should be thought of as simple 'quality control', or the need for managers to 'walk the floor'. In our context it is achieved by managers sampling sessions from time to time to check that they are being run as envisaged. In this way, they can identify potential weakness before it is too late, and identify further training which may be required. Moreover, it is also a process which has the potential to support, encourage, and inform leaders.

To be fair, sampling this particular river-walk in normal conditions would not have made any difference to the outcome. The problem was the unusualness of the circumstances.

8. It is not what you write which drives safety, but what you do. Doing the right thing by unusual means is acceptable, whereas doing the wrong thing 'by the book' is not. There is a growing misunderstanding amongst worryingly influential people that merely writing a risk assessment in some way will protect people from harm. All across the country line managers seem only to ask "Have you done a risk assessment?" No-one seems to ask these days "Are you competent?"

   The leaders of the afternoon group had not carried out a written risk assessment. The leader of the morning group had, but in spite of this both groups got into almost identical difficulties.

   The morning group's risk assessment had identified the importance of checking the river's level, but there was no indication of what 'too high' was. In the end the morning group continued with their proposed river walk because their risk assessment did not steer them to **do** anything differently.

   The limits of a risk assessment lie in the experience of the authors, and none of the people involved that day had experience of the unusual circumstances before them. Few from Leeds LEA had experience of those conditions.

Conclusion

It is the observation of the Adventure Activities Licensing Authority that most accidents, even most serious and fatal accidents occur on the activities which were considered before-hand to be the lowest risk. One might feel that the lessons identified above are merely common sense, but time and again evidence suggests that even common sense measures were not followed, largely because

those involved believed there was no risk. I strenuously urge every teacher and youth leader who leads groups of young people to realise that NO outing is risk free. Moreover, society expects them to fulfil their responsibilities conscientiously, and with the same attention to detail as a professional instructor would on more demanding activities.

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