Tenth Anniversary of the Mangatepopo Tragedy, – Lessons Learned

Three years ago we ran this feature in Adventure by Neil Silverwood

Mangatepopo Tragedy, Seven Years on – Lessons Learned

I'll always remember the moment I heard about the Mangatepopo canyoning tragedy. I was studying outdoor recreation at Christchurch Polytechnic, finishing my degree, when news came through that seven people were missing after being swept down the Mangatepopo River Gorge, a deep conglomerate canyon in the North Island's Central Plateau.

When I heard the news I felt the same sickening feeling of dread I always feel when hearing of accidents in the outdoors. New Zealand’s outdoor industry is small and, like in past accidents, I had a strong connection with the event. Five years previously I’d been employed by the Sir Edmund Hillary Outdoor Pursuits Centre (OPC) and had guided many students down the gorge. I could vividly remember every section. My tutors had also worked there so we stopped what we were doing and tuned into the news. Early reports were lacking in detail and it wasn’t until the next day that we heard the full, grim report. Six students and one teacher had been swept over a dam at the base of the canyon and had drowned. I truly felt for the students but also as much for the team at OPC. Many of the staff had been involved in the rescue attempt and eventual body recovery. I could only imagine how terrible this must have been, particularly for the instructor involved.

Several months ago Steve Dickinson, the editor of this magazine, contacted me and asked if I would write a piece on the Mangatepopo tragedy for the survival issue. Because I had recently finished a short-term contract with OPC, I contacted them to discuss the article and get their approval to publish it. I got in touch with Graham Seatter, OPC's capable new CEO, about the idea – Graeme was open but wary. "Hasn't all this been covered before?" he asked. "It happened over six years ago." While I can appreciate Graham's opinion, I don't think it has been reported on fully. Although the media did initially cover the story there has been very little follow-up on the tragedy in the form of a documentary or in-depth reporting since. By the time the Coroner's report was released two years later, people had lost interest. The vast majority of outdoor instructors likely know only the most rudimentary details while the general public knows even less. With no disrespect intended for Graham, I think it's important to share information about the tragedy so that we can all learn from the past.

It's hard to know where to begin telling the story. Let's go back…

Jodie Sullivan, who was the instructor on the fateful canyoning trip, began employee training at OPC in January 2008. She had just completed, in December 2007, the Outdoor Educators Course – a 12-week programme designed for mature people with life experience to become outdoor instructors. Prior to this, Jodie had studied for a Bachelor's Degree in Physical Education. Many students on the Outdoor Educators Course come from teaching backgrounds, it's a fast-tracked way to get into the outdoor industry and successful graduates compete for jobs with others who have completed two to three years of study in Outdoor

Recreation. Many outdoor instructors at OPC came to the organization via the Outdoor Educators Course.

When she started, Jodie completed an induction and was put on a training block. At the time, trainee instructors received half the salary of a full instructor and while training, they are meant to be given direction, support, and a mentor. The role of a mentor was to provide one on one support for new instructors and an experienced instructor who would job was to watch over a new instructor and critically look at their decisions. Unfortunately OPC failed to provide a mentor.

On Monday, the 14th of April, the day before the tragedy, Jodie was one of five instructors assigned to a group of 16 year-old students from Elim College, Auckland. The group was divided up between the instructors and Jodie was leading ten students and a teacher. Taking these students on her own was one of Jodie's first challenges as an outdoor instructor and being a trainee, she should have had a mentor and a solid base of support, however she had neither.

The next day, April 15th, Kerry Palmer, the OPC Field Manager, read the weather forecast at the 8am staff meeting. It was grim and called for rain with poor visibility easing to showers that evening. There was a safety auditor present that day working with Palmer and the instructors. She wasn't however, privy to the final call that was made regarding Jodie and the gorge. At the meeting, three instructors gave their intentions to run upstream gorge trips that afternoon. The upstream gorge trip is less committing and less intense than the downstream option as it only goes up the canyon to the halfway point and is easier to turn

around mid-trip. Given the improving weather forecast, Palmer was comfortable with their intentions.

One instructor took a group of students up Mt Pukekaikiore, a mountain in the headwaters of the Mangatepopo River catchment. In the early afternoon he noted that streams were beginning to form in normally dry creek beds. Although she was unaware of water levels rising on the mountain, Jodie made the decision to take her group to the manmade dam situated at the bottom of the Mangatepopo River Gorge despite the fact that it had began to rain heavily. She arrived with her group at the dam at 1pm. She had already discussed her plans with Palmer by radio and he had advised her that he had concerns of water level rising in the gorge due to the heavy rain. Jodie told Palmer that she would evaluate the situation once she reached the dam and could assess the water level. She said she might not go very far into the gorge with the idea of doing some team building games at the dam. It is noted that when Jodie reached the dam the water had risen slightly but was still flowing clear. The Coroner's Report states, "He [Palmer] acknowledged that he did not tell Ms. Sullivan that she could not go into the gorge. Ms. Sullivan appeared confident to him, and that she had a clear strategy for the activity. Between 2-2.30pm, following a particularly heavy period of rain Palmer drove down to the dam to check the water level. At that time the river was flowing strongly and he assumed the group must have taken shelter on one of several ledges above the river as it would have been difficult to navigate the swift waters. There is no radio communication where Jodie's group was waiting upstream in the gorge and Palmer had no way of knowing exactly where they were or of accessing them (due to the terrain) had he known. Meanwhile, the group had made it to the halfway ledge, which is the turn around for OPC's usual upstream gorge trip, and had begun their descent. On their way back downstream they found the water was flowing faster than before and was rising, and they had to work hard to overcome the increased flow. To cross one of the final rapids the students required assistance from Jodie using a throw bag. By then the water had become brown in colour. Due to the crossing delay and the rising water Jodie made the fateful decision to stop on a small ledge only 50 metres from the exit to wait it out. When they stopped, the ledge was just above the river but as they waited the water level became ankle deep and then knee deep and then they had to actively hold onto the rock wall to keep from being swept away. At this point, Jodie chose to lead the group out of the gorge. She made the flawed decision to pair the weakest students in the group with several of the strongest and attached them together to swim downstream to where she would throw bag them out just above the dam. Students who didn't catch or couldn't manage the throw bag were

quickly swept over the dam into a manmade hydraulic feature five meters below. Six students and one teacher died after being swept over the dam.

Before we look back at what learning we can take away from this tragedy, we need to look at our record in the past. This was not, by a long shot, the first outdoor education accident in New Zealand. There have been multiple fatalities including two deaths at OPC, one of which was in the same canyon. In fact, in my mind, one of the underlying causes in this event was lack of institutional knowledge. These accidents are not often discussed and staff at the time would only have known about them if they had done their own research.

A major contributing factor in this event is that OPC had a high staff turn over in 2008. Instructors were only staying about six months to one year at the centre. I believe it takes at least six months to a year to become proficient as an outdoor instructor. The fast turn over meant that by the time an instructor reached competency they were leaving. The high turnover also lead to a vacuum of knowledge about past incidents; I suspect Jodie would not have known about the previous losses and the events that lead to them.

The Field Manager at the time of the incident was Kerry Palmer who is very safety conscious. From my experience, he always asked instructors critical safety questions at appropriate times. At the same time, he gave staff a high degree of decision-making freedom so they could give students real, quality adventures; staff were allowed to take on the lion’s share of responsibility, so to speak, when choosing activities. Kerry’s way of working relied on the experience and personal

judgement skills of the instructors. In this case the other two instructors planning to enter the gorge that day made the correct decision. Jodie was new at the job and lacked the depth of experience needed for such calls; she made the wrong decision.

We can learn a few key things from analysing her actions. First, new staff need a high degree of support. This is primarily the role of the training officer. Resources such as a spare staff member should be available to jump in and help instructors run activities they don't have the experience to facilitate. Another concern is the amount of freedom given to new, inexperienced staff. Outdoor centres with new staff should rely heavily on pre-set rules rather than simply on instructors' judgement. For example, rather than an instructor arbitrarily making the call whether or not to enter a gorge, they may have a guideline that states when it's raining students do not enter the gorge or, when water flow reaches a set point on a flow meter, gorge activities are cancelled. This gives them clear boundaries to work within. Once a staff member has external competencies, such as their NZOIA qualifications, they can be given more freedom. We need to be extremely cautious when we have loco parentis, people who send their children to OPC put complete faith in the organisation. They believe that their children will be exposed to a high degree of perceived risk and a small amount of real (actual) risk. We need to ensure the level of actual risk, when dealing with children/young adults is very low.

The Mangatepopo Tragedy has been the worst outdoor recreation accident in New Zealand with perhaps the exception of the Cave Creek structure collapse. I've been back to OPC recently and believe they now have some of the most robust safety systems of any outdoor company operating in New Zealand; the centre has become an industry leader in safety. Like OPC, the outdoor industry as a whole has been undergoing a massive change in regards to safety management. As of November 2014 all guiding businesses and outdoor education providers (with the exception of government funded organisations such as schools) are regulated and are required to have annual audits which scrutinise their Safety Operating Procedures (SOPs). Any trips considered high risk, such as water activities, must be checked and approved by a technical expert. While the system is expensive and has flaws (it only see's what's happening on the day the auditor is visiting), it offers the most comprehensive safety check yet. When I spoke with Graham Seatter he was quick to point out though, no matter how good your safety procedures are, actual safety in the field still relies on decisions made by the instructor. To minimize the risk, OPC has made some procedural changes. For

instance, the centre has shifted from a judgment type model towards a strong policies model. Each day a weather forecast is read out and an operating status chosen as red, yellow or green. Green means that all activities are open, yellow means caution, radio's on at all times, and red means that water based activities, such as the cave, are closed. Each activity also now has SOPs which instructors must read, sign and carry. They highlight all of the critical information instructors need to know before undertaking an activity and, perhaps more importantly, previous incidents and accidents. SOPs are regularly updated to include new hazards.

Every outdoor instructor knows that there is always the possibility of loss of life during adventure activities; it is the worst-case scenario. However, outdoor education is still very important. It gives people a connection between themselves and the outdoors and fosters environmental care, personal strength and physical fitness, among other things. It also teaches us about adventure, and how to work with other people – concepts that are critical in education and personal development. OPC has run thousands of successful programmes that have enriched many students' lives. The centre made a mistake and as a result went through a roller coaster of changes. It has now been rebuilt and come out stronger than before. It has also been rebranded as "Hilary Outdoors" and is even considering re-opening the gorge trip, which has been described by one staff member as the crown jewel of the centre.