



FINDING OF CORONER UNDER  
CORONERS ACT 1988

I, DAVID OSBORNE CRERAR, Coroner at Rangiora hereby certify that at an inquest completed on the 6<sup>th</sup> day of November 2002 at the Courthouse, Rangiora having enquired into the time, place, causes and circumstances of how HAYLEY ANNA NORTH of 21 Harrogate Street, Hanmer Springs, Student died I found:

THAT HAYLEY ANNA NORTH of 21 Harrogate Street, Hanmer Springs, Student died on the 26<sup>th</sup> day of October 2001 at Clarence River, Hanmer Springs as a result of drowning with minimal water inhalation indicating rapid demise following immersion from a capsized canoe. The death occurred whilst the deceased was a passenger in a Canadian Canoe which became lodged in a rock when traversing rapids and the deceased was trapped underneath the Canoe.

Dated at Rangiora this 14<sup>th</sup> day of July 2003

..... Coroner  
D O Crerar

NOTE: This form together with the depositions, the prohibitions on publication and, where applicable, a certificate of registration of death, must be forwarded to the Secretary for Justice by the Coroner completing the inquest.

IN THE CORONER'S COURT  
HELD AT RANGIORA

IN THE MATTER

of an Inquest into the death of  
ANNABEL ATKINSON and HAYLEY  
NORTH

Hearing: 6<sup>th</sup> November 2002

Before: Coroner D O Crerar

Present: Sergeant R Pabst for the Police

Mr S Hembrow, Counsel for A Clayton & Hanmer Outdoor Experience

Witnesses: Sergeant D Harvey for the Police  
Mr N J Batten – Former Principal Hanmer Primary School  
Mrs N A Atkinson – for the Atkinson Family  
Mr D S Erikson – Rapid Action Ltd  
Mr A J Clayton – Hanmer Outdoor Experience  
Mr M Eno - Maritime Safety Authority  
Mr B Whitley – Maritime Safety Authority  
Mrs R Phillips - Ministry of Education – Christchurch  
Mr B Ward – Water Safety New Zealand  
Mr M Smith – Hanmer Primary School Board of Trustees

Other Parties: Mr P & Mrs G North  
Mr B Atkinson

Media Representatives  
- Northern Outlook  
- Christchurch Press

Date of Interim Finding: 13<sup>th</sup> June 2003

Date of Formal Finding: 14<sup>th</sup> July 2003

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DECISION OF CORONER D O CRERAR

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At approximately 11am on the 26<sup>th</sup> October 2001 a Canadian Canoe "Lynne Cee" was trapped by water pressure against a large rock in the Clarence River near Jollies Pass

Road, north of Hanmer Springs. Two occupants of the canoe were trapped by water pressure between it and the rock, were unable to escape, and died. The exact mechanism of the deaths was, in the case of Annabel Atkinson not drowning but an asphyxia or crushing which prevented her breathing. Hayley North "drowned" but the Post Mortem of Dr M D Sage noted that she succumbed rapidly.

The narrative of the circumstances leading up to the deaths is outlined precisely in the Maritime Safety Authority Report number 01 2766. For the sake of completeness I summarise the circumstances of the death as follows:

Early on the morning of the 26<sup>th</sup> October 2001 a party comprising Andrew Clayton, (owner and chief guide for Hanmer Outdoor Experience), a Hanmer Springs Primary School Teacher Mrs Joan Vowles, a parent aid, Mrs Nicola Atkinson and seven pupils from Year 7 at Hanmer Springs Primary School, left the school in two vehicles for the approximately 30 minute journey over Jacks Pass to the Clarence River. Mr Clayton drove, with most of the party, in his Landrover towing a trailer which was loaded with five Canadian canoes including the "Lynne Cee".

The "Lynne Cee" was a Canadian canoe approximately 9 years old. It was 5.2 metres long and 0.84 metres in width. Its hull was constructed of polyethylene with wooden cross members and cross thwarts on either side of the canoes midpoint. These strengthened the hull and provided a fixture for a central buoyancy chamber. The gunwales were constructed of aluminium and plastic modified by the addition of heavy gauge plastic pipe to give additional protection from physical damage.

The only floatation device used in the "Lynne Cee" was the central buoyancy chamber.

MSA advised that when "Perception" (the manufacturer), supplied the canoes fully assembled, they were fitted with blocks of polystyrene located at either end of the canoe. It is accepted that the "Lynne Cee" was operated at less than the manufacturers conservative estimate of loading at 250 kilograms. The loading of one adult and three children may not have been the ideal configuration.

The manufacturer was of the opinion that the canoe could be used in rivers containing up to and including Grade 3 rapids. Canoe operators, consulted by MSA, were of the opinion that the Perception Canadian Canoe was suitable for use only in rapids up to and including Grade 2. I note opinion to the effect that Canadian Canoes are more difficult to operate, and handle, than a conventional kayak, particularly in swift water.

On arrival at the "put in" site on the river bank, Andrew Clayton unloaded the canoes and arranged for the party to be clothed in the appropriate safety clothing. This included a polypropylene top, a wet suit, a light weight parka and helmet for each.

Andrew Clayton and Mrs Atkinson, in their respective vehicles, drove several kilometres down the road to the "get out" where the Landrover and trailer were left. Both then returned to the remainder of the party. Andrew Clayton then commenced a thorough briefing which included instruction on how to paddle the Canadian Canoes and safety precautions. The group was then divided into teams and further "on water" instruction was given.

There is debate about the length of time of each of the practice paddles conducted in smooth water upstream from the "get in" point. The instructor noticed that one crew was having difficulty in navigating its canoe correctly. He suggested (required) a change of crew and a change of position of paddlers, within the canoes. The occupants of "Lynne Cee" did not change. Following the practice sessions the other two canoes followed the canoe of the instructor down stream to a position slightly up river of the area containing "Rock A" upon which the canoe "Lynne Cee" later became trapped, and termed the "Rock Garden". Annabel Atkinson, at this stage, expressed concern about the rapids, which were clearly visible from that position, and insisted upon joining Mrs Nicola Atkinson, her mother, in "Lynne Cee".

Andrew Clayton was first through the rapids in his canoe. The next canoe started to descend the rapids but the occupants experienced difficulties. The canoe, after striking a partly submerged rock and turning through an arc of 180 degrees, passed through the rapids backwards before reaching the river bank.

The crew of the "Lynne Cee" were signalled to by Andrew Clayton to commence their descent of the rapid starting a short distance upstream from "Rock A". The "Lynne Cee" was swept sideways, the bow of the canoe was facing downstream directly for the rock. The crew managed to turn the canoe to the right in an attempt to clear the rock but the canoe was caught by the current and was swept broadside onto the rock.

As stated in the MSA Report "initially, as the canoe rode up the pillar of water in front of the rock, the upstream facing gunwale (the top of the side of the canoe) leant over towards the surface of the water. At this juncture the crew acted as they had been taught and hugged the rock by leaning towards it so that the downstream side of canoe leant in the opposite direction namely, towards the rock. As that happened, the downstream amidships gunwale dipped and water from the pillar of water flowed into the boat, causing it to swamp quickly. This combined with the action of the crew, who were already leaning towards the rock, caused the downstream side of the canoe to sink underwater."

In response to the submissions by Counsel for A J Clayton (Hanmer Outdoor Experience) I accept the observation by Mr Whitley that this is an unusual occurrence as normally the canoe would turn away from the rock.

When the "Lynne Cee" started to sink Nicola Atkinson and the male pupil who had been in the front of the canoe, were dislodged and swept down stream. Hayley North and Annabel Atkinson, who had been in the centre of the canoe, were left trapped between the canoe and the rock. The hydraulic force of the water held the submerged canoe firmly against the rock.

Andrew Clayton and Nicola Atkinson made several attempts to swim to the rock but were unable to gain sufficient grip on it or on the canoe. While Andrew Clayton continued rescue attempts, Nicola Atkinson, Joan Vowles and a student ran back to the car at the "put in" point and drove to the Landrover at the "get out" point. They collected the instructor's cell phone from the Landrover and travelled back towards Hanmer Springs until cell phone reception was obtained. Police Southern

Communications, in response to the 111 call, activated local police, ambulance and helicopter rescue services.

Rescue, or recovery, attempts by the Police, by the Hanmer Springs Volunteer Fire Brigade (personnel from which included two persons skilled in white water rescue) and the Westpac Trust rescue helicopter with a water rescue team, all failed to gain access to the canoe and it was not until approximately two and a half hours after the canoe became trapped against the rock that a mechanical digger was able to dislodge the canoe. As the canoe was swept downstream the bodies of Hayley North and Annabel Atkinson were able to be recovered.

At the Inquest hearing on the 6<sup>th</sup> November 2002 evidence was given by: Sergeant D Harvey of the Amberley Police who gave an outline of the circumstances of the deaths and presented the formal documentation required by the Coroners Act. This included formal evidence of identification, Certificates of life being extinct and copies of the Post Mortem reports.

A number of further witness including Mrs Nicola Atkinson, Andrew Clayton, Mr Neil Batten (former Principal of Hanmer Springs Primary School) Mike Smith ( chairman of the Board of Trustees of Hanmer Springs Primary School), Mrs Rosalie Phillips (Ministry of Education), Mike Eno of the Maritime Safety Authority, Brent Whitely an independent expert employed by the Maritime Safety Authority and Dave Erickson of Rapid Action Ltd (an independent expert employed by the Police) also gave evidence. The Inquest is grateful to each witness, for the candour with which evidence was given and the frank and honest answers to questions. In a situation which a witness may have been forgiven for taking a position which could be seen as self serving each co-operated to the fullest extent by giving responsible answers.

At the time of the preliminary Inquest hearing I asked that representatives of the Ministry of Education first forward to me, and then be prepared to give evidence on, the resources available to schools as they relate to "Education Outside The Classroom" (EOTC).

Mrs Rosalie Phillips appeared at the Inquest and made a statement on behalf of the Ministry. A number of briefing papers were produced at the hearing. Of particular relevance are "Education Outside the Classroom Guidelines for Good Practice 1995" [exhibit 14] "RAMS matrix EOTC policy" [exhibit 10A], and "Frequently Asked Questions [exhibit 10f].

Following the drownings of two school pupils during a school outing near Waimate on the 10<sup>th</sup> February 2000 and the drowning of two pupils during a school activity near Thames later in February 2000, the Ministry of Education commissioned a report and set up a working group which made recommendations to the Ministry. A reference group comprising outdoor experts and relevant education professionals was then established. One task of this reference group was to draw together all EOTC documentation from what I understand to be a large number of published materials into one "resource". The compilation of this "resource" and its dissemination to schools has been painfully slow. The original contracted writer reported to the reference group early in November 2001 but the reference group effectively rejected the draft and contracted another writer. I was told that a new EOTC "resource" was scheduled for delivery in December 2002. I trust that this "resource" draws heavily on the circumstances of the deaths recorded in Waimate, Thames and Hanmer Springs and imposes greater responsibilities upon Boards of Trustees and Principals when planning outdoor activities for school pupils.

A significant flaw in the documentation produced to the Inquest relates to the issues of ratios. The publication "Frequently Asked Questions" does give direct guidance but the issue appears to have been overlooked in the planning of the activity on the Clarence River. The prima facia ratio for the canoe expedition would have been seven (7) pupils to three (3) adults. In fact, because of the lack of experience of the teacher and parent help, the ratio was one instructor to nine (9) pupils. The ratio was clearly insufficient and inappropriate to the activity.

The "Guidelines For Best Practice" I have referred to, is comprehensive in its procedures and obligations. The guidelines require planning and a safe management

system incorporating an appropriate RAMS (Risk Analysis and Management System).

The Principal appeared aware of the obligations, but, in retrospect, took insufficient care in analysing all implications.

The deaths of Annabel Atkinson and Hayley North were (in retrospect) both foreseeable and preventable. The excursion by Canadian Canoe on the Clarence River was an activity which involved hazards which were either not recognised or were misunderstood.

The Ministry of Education has created guidelines for Education Outside the Classroom (EOTC). The Resource, at the time of the activity in October 2001, was outdated but was not in any event followed closely or carefully enough by the Board of Trustees or the Principal of Hanmer Springs Primary School.

The Ministry of Education delegates its responsibility for EOTC to a Board of Trustees.

The Board of Trustees delegated its responsibilities to the Principal.

The Principal delegated responsibility for the activity to the operator considering, without an objective assessment, that the operator was a safe operator.

The operator, again without an objective assessment, thought that he was a safe operator.

A school may rely on the Standard Operating Procedure (SOP) provided, by its contractor, if that plan meets with the defined standards, analyses all hazards in relation to the activity to be undertaken and identifies steps which should be taken to eliminate all hazards from the activity. It is the responsibility of the school (both Board and Principal) to consider and critically analyse the SOP, and to acknowledge in a written contract with the contractor, the agreement and responsibilities of each. This did not occur.



The particular hazard which was not identified either to or by Andrew Clayton is the area in the Clarence River known as the Rock Garden and specifically "Rock A".

David Erickson, in his evidence, clearly notes "Rock A" as an identifiable hazard requiring special care and consideration by an operator.

The adventure aspect of the canoe trip for the pupils would have lost little of its essential element of removing participants from their comfort zone if Andrew Clayton had beached his canoe below the Rock Garden and returned to pilot the other two canoes through an area (identified by both David Erickson and the MSA) as being essentially the only hazard, of its nature, which required to be negotiated. The situation ought to have been particularly recognised by Andrew Clayton when the second canoe on the river, experienced difficulties in navigating around the hazard.

Mrs Atkinson has asked that I specifically refer to the compulsion for a pupil to participate in an adventure activity. The EOTC publication "Guidelines for Good Practice" already referred to, identifies and analyses these issues.

It is implicit within EOTC, or adventure activities generally, that a participant be taken out of his or her comfort zone and be extended physically and mentally to add to a growth process. It is apparent that, at some stage, if taken too far, the extension can become counter productive.

Obviously the desired result of a challenge is for the person challenged to view it retrospectively as an enjoyable and enriching experience. If the challenge is too great the benefits may be lost.

Annabel Atkinson was clearly frightened at the prospect of canoeing, particularly expressing anxiety in relation to the white water rapids in the Rock Garden.

Andrew Clayton recognised and reacted to this concern at least to the extent of allowing Annabel Atkinson to change canoes. In retrospect, of course, this action lessened the

benefits of the previous training and crew bonding experience.

I repeat the observation that, in retrospect, it would have been preferable for Mr Clayton to have personally piloted each canoe through the obvious hazard.

There can be no criticism of Mrs Nicola Atkinson in respect of her participation in the activity. She was placed in a position she ought not to have been placed in. The activity was flawed by the need for parent (instructor) ratios required for the system. I trust that this problem has been recognised and rectified.

The condolences of the Court are extended to Mr & Mrs North, Mr & Mrs Atkinson, their families and the wider community in respect of these sad and tragic circumstances.

I commend all of those who participated in the rescue efforts on the river. In impossible circumstances those involved did their very best to help.

My formal findings are as follows:

I find THAT HAYLEY ANNA NORTH of 21 Harrogate Street, Hanmer Springs, Student died on the 26<sup>th</sup> day of October 2001 at Clarence River, Hanmer Springs as a result of drowning with minimal water inhalation indicating rapid demise following immersion from a capsized canoe. The death occurred whilst the deceased was a passenger in a Canadian Canoe which became lodged in a rock when traversing rapids and the deceased was trapped underneath the Canoe.

I find THAT ANNABEL DIMITY ATKINSON of 360 Woodbank Road, Hanmer Springs, Student died on the 26<sup>th</sup> day of October 2001 at Clarence River, Hanmer Springs as a result of compression asphyxia complicating immersion and entrapment in a capsized canoe. The death occurred whilst the deceased was a passenger in a Canadian Canoe which became lodged in a rock when traversing rapids and the deceased was trapped underneath the Canoe.

RECOMMENDATIONS:

1. I recommend that Hanmer Outdoor Experience and Andrew Clayton as Owner / Manager not operate Canadian Canoes in future without retraining, without obtaining a formal qualification and without ensuring an adequate pupil / instructor ratio be adopted. (It is noted that I have been advised that since October 2001 neither Andrew Clayton nor Hanmer Outdoor Education have conducted any activities involving the use of Canadian Canoes).
2. That the Ministry of Education should review its EOTC programmes, if it has not already done so, particularly as some relate to water activities. If a school embarking upon a EOTC event employs a contractor it must be the responsibility of the school Principal and the Board of Trustees to develop its own Safe Operational Plan (S.O.P.) in order for the school to manage the safety of its students, parent helpers and teachers. It is the Board of Trustees which ultimately accepts the responsibility for safe practice.
3. That the Ministry of Education, should emphasise to schools that ,when setting a pupil / instructor ratio, the nature of the activity to be undertaken and the degree of skill or experience necessary and appropriate for that activity is taken into account. If an adult is not skilled or experienced in the particular activity the presence of that adult should not be taken into account when calculating the ratio. The adult should be treated as a student for this purpose. The Ministry of Education should reappraise all activities comprising EOTC and recommend appropriate instructor / student ratios for each such activity.

ADDENDUM

In a submission to the draft Finding circulated on the 13th June 2003, Counsel for A J Clayton (Hanmer Outdoor Experience) raised a number of matters for my further consideration. A number of these submissions have resulted in a re-editing of the

Finding. I thank Counsel for his input.

The major concern expressed by Counsel was my comment in relation to the failure by Andrew Clayton (Hanmer Outdoor Experience) to identify "Rock A", and the Rock Garden as a hazard, or misunderstanding the hazard it presented. I accept that Andrew Clayton (Hanmer Outdoor Experience) did recognise "Rock A" as a hazard. This recognition resulted in Hanmer Outdoor Experience beaching the canoes prior to the Rock Garden, inspecting the area and running the rapids one canoe at a time.

I clarify my position:

Andrew Clayton (Hanmer Outdoor Experience) appears however not to have recognised the seriousness of the hazard which "Rock A" presented to inexperienced canoeists in a Canadian Canoe.

Mr David Erikson in his Report Summary notes

"The rock concerned poses a significant river hazard to recreational boaters especially beginner kayakers and open canoeists in self guided boats even at low levels" and

"The level of prior training of the participants was not adequate for the conditions nor was Hanmer Outdoor Experience's hazard identification".

It remains my opinion that Andrew Clayton (Hanmer Outdoor Experience) did not truly appreciate the serious hazard presented by "Rock A".

Counsel has further suggested that the paragraph

"The operator, again without any objection assessment, thought he was a safe operator", is unfair.

I accept that the Maritime Safety Authority Report notes

“The owner was renowned for his safe attitude and application of safety techniques.”

I accept also that there had been no appropriate training courses which Andrew Clayton could have attended in the several years preceding the Lynn Cee accident.

There are, however, independent safety consultants which as Mr Erikson and Mr Whitley who could have been available to Hanmer Outdoor Experience to give that organisation an updated and objective safety review of its operations.

I refer to the part of the evidence of Mr Erikson of Rapid Action Adventures Ltd headed “Safety Management” , with particular reference to Safe Operational Plans.

I commend outdoor education operators to have their activities reviewed on an objective basis by an outside expert.

I also received a submission to the draft Finding from Neil Batten Principal of Hanmer Springs Primary School at the time of the deaths of Annabel Atkinson and Hayley North.

Neil Batten notes that there is little support for a Principal (or a Board of Trustees) from the Ministry of Education to enable an objective assessment to be made of the S.O.P. produced by an outdoor education operator. This observation is accepted. A copy of the formal Finding will be forwarded to the Ministry of Education which I hope will investigate this aspect further. Neil Batten confirms that he met with Andrew Clayton (Hanmer Outdoor Experience) twice to discuss the activity, carefully read the S.O.P. and considered, with the information then available, that the activity would be conducted safely.

Neil Batten did all that may have been reasonably expected of him at the time he approved the activity. In hindsight it is clear that the process was flawed. Mr Batten and the Board of Trustees were not qualified or trained to make the assessment

required of them.

In my letter circulating the preliminary Finding sent on the 13<sup>th</sup> June 2003 I advises that the Finding would be published on or after 30<sup>th</sup> June 2003.

A letter, dated 10<sup>th</sup> July 2003, has since been received from the Ministry of Education. It advises that my recommendations 2 and 3 have been implemented apart from my request that the Ministry "recommend appropriate instructor / student ratios for each such activity".

The Ministry of Education advises that

"Ratios cannot be prescribed for specific activities per se. Appropriate ratios will vary according to student needs, age group, level of activity, location and competence of staff involved".

It is significant that it is this issue which concerns Neil Batten as a Principal. Principals and Boards of Trustees require guidance on matters in which they are not experts. The Ministry of Education has an EOTC Reference Group consisting of expert representations from education and outdoor sector groups.

I again ask that the Ministry of Education give more guidance to School Principals and Boards of Trustees in the setting of pupil / teacher . instructor ratios. The Ministry is better able to achieve this objective than are Schools.

Dated at Rangiora this 14<sup>th</sup> day of July 2003



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D O Crerar

Coroner