13 OCT 2000

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FINDINGS OF CORONER UNDER
CORONERS ACT 1988

*I, **JOHN ELLIOT SOPER JENKISON**, Coroner at **THAMES** hereby certify that at an inquest completed on the 11th, 12th, 13th and 14th of September, at the Thames Court House having enquired into the time, place, causes and circumstances of how **REVAN NAIDOO** late of 7/644 Pakuranga Road, Howick, Auckland, Student died, I found:*

*That the abovenamed **REVAN NAIDOO** died at Auckland Starship Hospital on the 15th February 2000 of hypoxic ischaemic encephalopathy and brainstem oedema following a near drowning.*

and pursuant to section 15(1)(b) of the Coroners Act 1988 I make the following recommendations or comments (if any): (see attached decision)

~~*and pursuant to the Coroners Act 1988 I have prohibited publication of certain evidence given at the inquest**~~

Dated at Thames this 9th *day of* October *2000*

.....
Coroner

**Delete if not applicable*

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
AT THAMES

IN THE MATTER OF AN INQUEST INTO THE DEATHS OF REVAN NAIDOO AND JOSHUA MCNAUGHT

DECISION OF THE CORONER

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INQUEST INTO THE DEATH OF REVAN NAIDOO AND JOSHUA MCNAUGHT

This is an inquest into the deaths of these two boys who died whilst attending a school outdoor education camp at the Kauaeranga Valley Christian Camp near Thames.

Education outside the classroom is now an important part of our national school curriculum and I quote from the introduction to the Ministry of Education Guidelines published in 1995:

"For many years New Zealand students of all ages have had their learning extended and enhanced through activities in, and or about the outdoors. These activities, whether supporting one essential learning area or linking several have become known as education outside the classroom. (EOTC) They are recognised as part of the curriculum".

The Kauaeranga Valley Christian Camp is well suited to the implementation of education outside the classroom activities. It is located in the Kauaeranga River Valley just outside Thames and provides accommodation, dining facilities and a range of outdoor pursuits, including swimming in the river, which runs adjacent to the camp at a distance of about 2 to 3 minutes from the camp facilities. The camp is popular with schools and has about 20 separate camps in each of terms 1 and 4 of the school terms. In addition it has about 10 annual camps for its own members in every year. The age range of children using the camps is from age six to teenagers. The camp has a good safety record.

The swimming hole is in a confined area. It provides very shallow water over some rapids leading into the hole but there is then deep water described by the camp supervisor to the children as above his head (6 foot 3). There is also shallow water along the riverbank but this falls away sharply into the deep hole where the water slide and pontoon were located. Visibility under the water is limited and goggles are necessary to see.

Prior to coming to the camp schools are advised of the facilities that are available and in this case the school had used the camp on many occasions before, and in deed there had been one camp from the school the week prior to this tragedy. The information bulletin does not include any detail about the equipment at the swimming hole, which comprised of a water slide, and a pontoon which had been placed in the pool about 3 or 4 months before the camp. Senior teachers had used the camp before, but were unaware of the existence of the pontoon until the school party arrived at the camp.

Howick Intermediate School is a school with a roll of some seven hundred pupils divided into 20 composite classes of form 1 and 2 pupils. There are 6 camps a year. It draws pupils from many of the primary schools in the area and the two boys who died had just commenced attending the school. There were 2 composite classes of thirty pupils each attending the camp, although 1 pupil did not attend, leaving a total at the camp of 59. Miss MacDiarmid who attended the camp, is a first year teacher and was one classroom teacher. Mrs MacKenzie who had initially been responsible for organising the camp but was not available on the day, was the other classroom teacher.

Mrs MacKenzie, who impressed me as a witness, was the leader responsible for planning all camps and outdoor education for classes in her whanau group, which comprises of 3 or 4 classes.

Mrs MacKenzie as part of the preparation for the camp prepared a camp book which sets out all of the activities planned for the week and set out guidelines that were to apply to those activities. She also prepared a risk analysis and management systems report (RAMS) for potentially hazardous activities planned at the camp. For swimming she proposed dividing the students into four groups. There was to be one group swimming, one group waiting to swim, a group dam building, and a fourth group playing volleyball. The two swimming groups would be changed over after a given time or as students left the water. The school also held a meeting with parents of children attending the camp and the parents were also sent an information booklet with guidelines concerning the role and responsibilities of parents attending the camp. Much of the childrens early attendance in the school year related to the camp. Thus I believe that the school had prepared for the camp in a thorough and efficient manner, and substantially in accordance with Education Department guidelines.

On the Wednesday evening immediately prior to the commencement of the camp Mrs MacKenzie became aware that she would not be able to attend on the first day because of the hospitalisation of her daughter. Another senior teacher, Mrs Pinson, was asked to take over from Mrs MacKenzie for the Monday, and Mrs MacKenzie also became aware there would be only six adults accompanying the children on the first day, with further adults to follow the next day. She discussed this situation with the deputy principal, Mr Holt, and it was decided that although the ratio of adult to children was 1 to 10 instead of 1 to 8 as per the schools guidelines that this would be adequate for the first day as the school party was not arriving at the camp until late on the Monday, thus leaving a very limited time for outdoor activity, before the evening meal and bedtime. Whilst this decision may have seem reasonable at the time, as events transpired, it looms as being of critical importance. The camp book showed six parents were set down for the Monday when only four actually went. The camp book also shows a further five parents would attend on the Tuesday.

Mrs Pinson, Mrs MacKenzie, Miss McDiarmid and the children attending the camp had a further meeting on the Friday before the camp when Mrs MacKenzie went over with the children the instructions about safety aspects of the camp including the rules for swimming and listening to adults and whistles. Mrs Pinson was shown the camp book and risk management report on the Monday before the party left. The party arrived at the camp shortly after 4pm. They were given time to set up there bunks and then there was an orientation talk with Mr Popping the camp director. He then took the entire group on an orientation tour of the camp. This finished at the swimming hole at about 5pm and Mr Popping explained to the children where the deep and shallow parts of the pool were. Mrs Pinson then spoke to the children herself highlighting the dangerous areas and the rules for using the swimming hole. It was decided there would be no volleyball so that all the children could be kept together in one group.

The children were divided into 3 groups. There were about 20 pupils that wanted to swim a further 20 or thereabouts who did not want to swim but wanted to play in the dam area (the shallows) and there were a further group that did not want to do anything, and they either played or sat talking behind where Mrs Pinson was standing on the bank.

Initially 10 children were allowed into the water with Miss MacDiarmid, 2 parent helpers then entered the water, and a further 10 students were allow to go in.

At this point I believe that given the number of parents available, the children were correctly and sensibly placed in accordance with a zoning policy. Miss MacDiarmid was in the water, a further parent was in the water supervising the use of the pontoon, another parent was in the water supervising the water slide, a further parent was supervising the children at the dam area, and there was one further parent on the grass bank also keeping a look out for the children on the pontoon. That parent had to depart for about 5 minutes to provide first aid for 2 of the children who had wounds from cutty grass. Miss MacDiarmid left the water after about 25 to 30 minutes and stood with Mrs Pinson.

All of the children in the dam or shallow area then moved away from that area. Some may have swam over to the pontoon, but a number then joined the other children who had not participated in the swimming programme. These children did not have an adult directly supervising them. To compound the problem the parent supervisor who had been looking after the children at the dam, to avoid children swimming after them chased 2 foam cylinders that had moved into the river proper, and retrieved them at a short distance from where the children were congregated.

The children using the pontoon were rocking it back and forth, and there is evidence from and independent witness, Miss Manning that there was reason for concern of the behaviour of the children on the pontoon. Mrs Pinson said in cross-examination that she started shouting at the children to behave and her and Miss MacDiarmid's back would have been to the children who were by the riverbank.

There is quite an extensive shallow area of the river beside the riverbank but then it falls away steeply to deep water beside the water slide. It seems to me there were a number of children who would have been playing in the shallow area of the river at this time. If it had only been Revan and Joshua, then they would have been readily identifiable by the children themselves apart from the adult supervisors. Both Revan and Joshua had been at the dam area and had moved down to the riverbank. Remarkably after 3 ½ days evidence, there was only a deposition from one or perhaps two children as to what happened next.

It appears that Joshua who at best was not confident in the water, moved into the deeper water first. Revan started walking out towards him, and they both got into difficulty. Revan called out for help, and this was only heard by one of the children who did not really know what to do, until another child told Mrs Pinson of the difficulty that had arisen. Mrs Pinson blew her whistle to get the children out of the water and says in her evidence that she saw a white form in the pool under the surface. Prior to blowing the whistle she asked the parent by the slide, who was the nearest parent, to try and retrieve him. He was joined by another parent but they were unable to locate a body until Mr Chant, an assistant at the camp located it. CPR was then given, and I note that all parents present were able to give this assistance. This was about 5.30pm. The first body that was found was Revan's and when efforts to resuscitate him were unsuccessful and the ambulance arrived, the rescue helicopter was called. Its records shows that it left its base at 5.59pm and arrived at the camp at 6.50pm. It left for the hospital at 7.00pm and arrived at the hospital at 7.24pm. Thus, the trip to the camp took almost an

hour and there was some evidence that the helicopter first went to another camp in the valley, before it arrived at the Christian Camp.

Mrs Pinson sent a child up to the camp to get a head count. One of the parents completed a head count and got a number of 56, and she checked this again on 2 or 3 occasions and still came to a number of 56. Mrs Pinson thinks that the number she was told was 57 and as there was still one child on the bank, she thought that all of the children were accounted for. There was also some evidence that included in one of the counts was a child of the camps staff. There is some evidence from both Mrs Pinson and Miss MacDiarmid that Josh was the first person to be identified as missing when in fact the first body that was found was Revan's. They both became distressed following Revan's body being located.

It became clear from cross-examination that there was a doubt in the mind of both the parent helpers and at least Mrs Pinson as to the number of children that were actually at the camp. A roll call was finalised after the air ambulance left and Joshua's body was found at approximately 7.15pm or between 1 ¾ and 2 hours after the alarm was first sounded.

RECOMMENDATIONS

I think all Counsel are agreed that the powers of the Coroner are limited to those set out in section 15 (1)(b) of the Act whereby the Coroner may make recommendations or comments: -

"On the avoidance of circumstances similar to those in which the death occurred, or in the manner in which any person should act in such circumstances, that, in the opinion of the Coroner, may of drawn to public attention reduce the chances of occurrence of other deaths in such circumstances"

It is also true that an inquest is a fact-finding exercise and not a method of apportioning guilt.

In these circumstances perhaps the best method of highlighting from the evidence the problems that can occur in a school camp such as this is to show the circumstances that can divert the attention of the supervisors. Some of these circumstances may not have had a direct effect on the tragedy, but nevertheless are worth noting as follows: -

a) The non-availability at short notice of the senior teacher and organiser of the camp through the need to be present at her child's hospitalisation.

b) A parent who through work commitments was not able to confirm his attendance until the last minute, thus not being briefed.

c) A facility at the camp (the pontoon) that the teachers were not aware of.

d) Children requiring first aid.

e) A telephone call to a supervisor.

f) Flotsam drifting off into the river.

g) The unavailability of further parent help until the day following the tragedy.

h) One child who stayed at the riverbank, this helping to confuse the head count

i) Children skylarking (at the pontoon).

These incidents which may appear innocuous in themselves can compound to create the tragedy that arose. I believe there must always be at least one adult in reserve to provide supervision in the event of the adult supervision at the site being compromised. In the present instance that there was at least one adult short for the supervision of the children sitting on the bank or playing in the water nearby the bank. Thus, for a camp in these particular circumstances I believe that at least 2 further adults were required which still would have only given a ratio of between 1 and 7 and 1and 8.

There was obviously a serious problem with the head count of the children following the finding of Revan's body. I note that the camp itself when it conducts its own camps has cabin leaders with different coloured jackets and leaders are given a specific location to supervise. In the emergency that existed and under stress conditions the global number of 59 is too many, and I have no doubt that this caused confusion in the original head count. In an ideal situation I think an adult should be allocated a group of not more than 10, and it would do not harm to sit down with the group as part of the orientation process to get to know them a little better. There should of course be a list of the names of each child in the group. A camp leader should take the overall responsibility for a head count in emergency circumstances.

The camp used its fire siren to signal an emergency. I think that all camps of this nature should have a siren for emergencies, and its presence should be communicated to the users of the camp. There should be a designated area to congregate in the event of the siren being blown. By itself a number of signals on a whistle can be confusing to young children.

I believe that the use of a facility like the pontoon should vary according to the age and ability of the children at the camp. It is obviously difficult for a supervisor to control facilities such as this moored in the middle of a river if the behaviour of the children becomes a problem. The water slide is land based, and thus easier controlled.

Although I was not addressed on the issue, I think it is worthwhile noting that although the Education Act is confusing the 1995 Education Outside the Classroom Publication by the Ministry states as follows: -

"Boards of Trustees have the ultimate legal responsibilities for students in their care. They should acquaint themselves with all circumstances surrounding any outdoor programme".

It is my view that a Board cannot completely absolve itself from responsibility in situations such as existed here by saying that it is a management matter. Of course, it is up to the professional staff to provide the guidelines, policies and any specific detail of any camp. Nevertheless I believe that these details should be formally reported to the Board and in the present instance it would have been appropriate to advise the Board of

the concern that parent numbers were short on this particular day. Such a mechanism, if nothing else is, a further safety valve.
If there is one single message to be emphasised from this tragedy it is that if it is found that the number of adult supervisors is not sufficient, then the camp must be either postponed until there are sufficient numbers available, or cancelled, if they cannot be found. In this case, when I look at the camp book, it is obvious that the school was struggling to obtain sufficient parent helpers for the purposes of the camp.

This inquest has been stressful for all of the people involved, and particularly the families of the two children who have died. I can only hope that the full and comprehensive hearing has been achieved through the assistance of their Counsel can assist in alleviating their grief. Revan and Joshua were obviously fine boys and belonged to devoted families.

I hold therefore that Revan Naidoo late of 7/644 Pakuranga Road, Howick student died at the Auckland Starship Hospital on the 15th February 2000 of hypoxic ischaemic encephalopathy and brainstem oedema following a near drowning. I hold further that Joshua McNaught late of 6B Botany Road, Howick student died on the 14th February 2000 of drowning at the Kauaeranga River near Thames.

Once again I give my condolences to the respective families.

I shall be forwarding copies of my decision to the Water Safety Council, The Kauaeranga Valley Christian Camp and the Editor of the Education Gazette.

The names of the parent helpers and children have been suppressed.

J E S Jenksion
Coroner Thames Coromandel District