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FINDING OF CORONER UNDER CORONERS ACT 1988

I, PAUL GARY BROWN, Coroner at Taihape, Ohakune and Raetihi hereby certify that at an inquest completed on the 25th day of September 20 02, at the Taihape Courthouse
(Building at which inquest completed)

having enquired into the time, place, causes and circumstances of how

MATTHEW PHILLIP BROWN of 22 Lewis Road, Rotorua, Student
(Name, address, occupation)

died. I found:

he died on the 14th day of September 2001 as a result of grievous traumatic injuries to the lungs and head which injuries were received when he fell whilst skiing the Wintergarden Ski Area, Turoa Skifield, Mt. Ruapehu

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

that the John Paul College, Rotorua review its Education Outside the Classroom Policy to incorporate into that Policy the various recommendations as set out in my decision

and pursuant to the Coroners Act 1988 I have prohibited publication of certain evidence given at the inquest.* namely photographs 12 and 13 of exhibit 3

Dated at Taihape this 18th day of October 20 02

Coroner
P.G. Brown

** 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 Chief Executive of the Department for Courts by the Coroner completing the inquest.*

IN THE CORONERS COURT
HELD AT TAIHAPE

IN THE MATTER of the Coroners Act 1988

A N D

IN THE MATTER of an Inquest into the death of **MATTHEW PHILLIP BROWN**

DECISION

APPEARANCES

Mr M Callendar for the family
Mr G Dennett for John Paul College, Rotorua
Mr M McClelland for Ruapehu Alpine Lifts Limited
Constable J Mikkelsen on 28 August 2002 and Constable M Frost for the Police 25 September 2002

This is an inquest into the death of Matthew Phillip Brown. The Inquest was held over 2 days, 28 August and 25 September 2002.

GENERAL

In September 2001 the deceased was a member of a school trip from John Paul College, Rotorua, to Turoa Ski Field. There were 30 students on the trip with 12 adult supervisors. The group stayed at a Ski Lodge in Raetihi on 13 September. On the morning of 14 September the group left the Ski Lodge and travelled to Turoa Ski Field where a ski lesson had been arranged for the students.

Following the lesson the students dispersed. The deceased and two school friends took the Movenpick chairlift from the base of the skifield to the Upper Mountain. There they alighted and

then skied down the mountain. Whilst skiing down the Wintergarden area the deceased lost control, crashed and sustained injuries which were fatal.

In the course of the Inquest the planning, preparation and actions of Mr Kowalewski, the School Teacher in charge of the trip and to a lesser extent the Education Outside the Classroom policy and procedures at John Paul College at Rotorua came under scrutiny.

In his submissions on behalf of the family, Mr Callendar stated that the Inquest was not a witchhunt but rather an examination of what happened to see if in the future, the risks of what is an inherently hazardous exercise in going skiing can be reduced so as other families do not suffer as his client family has. Mr Callendar submitted that from the evidence in his opinion death in part had occurred because the right structures were not in place in respect of this skiing trip.

I now intend to examine these structures.

PROCEDURES

The ski trip fell under the ambit of Education Outside the Classroom (EOTC) Policy for the School.

The Policy is Exhibit 19 produced by Mr Kowalewski (page 106 of evidence).

The Rationale of the Policy is "to ensure John Paul College students are in a safe and worthwhile educational environment when participating in EOTC activities." (The underlining is 7mine.)

The Goals are to:

- develop students' personal confidence and self esteem;
- enhance students learning through enjoyable, safe, first-hand experience in a range of environments;

- advance students' skills in observation, recording, reporting and analysing;
- increase students' awareness of, and respect for, the similarities and differences existing between cultures, groups, individuals and the environment;
- give students opportunities to live and work with others in a wide range of situations and environments.

(Again the underlining is mine.)

The **Guidelines** and **Procedures** to achieve these goals were to :-

1. Offer students a wide variety of EOTC experiences.
2. Ensure that all involved with EOTC activities show respect for the values of maori and other cultures, the environment and equity issues.
3. Advise care givers and the community, giving appropriate advance notice.
4. Ensure all EOTC experiences are granted prior approval by the Principal.
5. Ensure that all procedures required in relation to planning, hazard management, risk management and supervision ratios are completed prior to the activity.
6. Ensure adequate ongoing training for all teachers involved in EOTC, including support for staff involvement in approved workshops, conferences, courses, and training and assessment schemes.
7. Follow Ministry of Education Regulations and Guidelines for Good Practice 1995, risk management, leadership, and legal requirements, including the Health & Safety in Employment Act 1992 and amendments.
8. Ensure the Principal has allocated appropriate ratios of adult supervisor to numbers of students for each EOTC experience. Consideration is to be given to the relative hazards involved in the EOTC experience in determining the ratio.
9. Ensure adequate, ongoing evaluation and annual review of EOTC programmes.

(Again the underlining is mine.)

I note:-

(a) the specific activity requires at No. 4 of the guidelines and procedures the prior approval by the Principal.

(b) No. 5 states that all procedures required in relation to planning, hazard management, risk management and supervision ratios are completed prior to the activity.

(c) By No. 8 the Principal of the School shall allocate appropriate ratios of adult supervisor to numbers of students for each EOTC experience. Consideration is to be given to the relative hazards involved in the EOTC experience in determining the ratio.

I find on the evidence that the procedure as laid down in the guidelines by the School and the procedures followed by Mr Kowalewski on this occasion are markedly different.

Mr Kowalewski stated that in practice any application for approval of an EOTC programme is referred to the Director of Daily Resources and the Director refers the application to the Senior Management Team at the School. If approved by this Team the application is then referred to the Board of Trustees (BOT) for final approval. Mr Kowalewski went on to say in evidence that approval was given for the same trip the year before and as approval had given by the BOT for that trip they did not need further approval for the trip in question.

No evidence has been tendered to me whereby I can be satisfied that the Principal has either given his approval to the trip or allocated the appropriate ratio of adult supervisors to the number of students as required. Nor am I satisfied that the Board of Trustees gave its approval to this particular trip the inference from the evidence being that because the Board had given approval to the trip the previous year that approval had

flowed over to this trip. I do note that there is nothing in the School Policy which indicates BOT consent was necessary, nor is there anything in the Policy which refers to a Director of Daily Resources being involved in processes or the role that the Director is to play in these processes. From Mr Kowalewski's evidence it appears that the Director is the middle person between the teacher organising the outdoor activity and the Principal, possibly also the Board of Trustees but that is not clear from the evidence.

I will return to the Policy later in the decision following examination of the evidence relating to a "safe" environment and "ensuring that all procedures required in relation to planning, hazard management, risk management and supervision ratios were completed prior to the activity."

Mr Kowalewski states that in his preparation for the trip he completed what is called a RAM form (Risk Analysis Management form). A copy of this was produced by Mr Kowalewski in his evidence as Exhibit 20. The form states "tick boxes that pertain to your trip." Mr Kowalewski ticked all but 2 boxes. All the boxes ticked (a total of 30) related to this particular EOTC activity. Having identified these as pertinent, I then looked for further confirmation in the form of documents to satisfy myself that plans had been prepared to address the pertinent matters. There was no such written confirmation. Mr Kowalewski said "I would have to take his word for it" meaning I could be satisfied that he had addressed those issues (page 99 of evidence notes). Mr Kowalewski produced as Exhibit 21 a Schedule. That Schedule was prepared by him following the first hearing day on 28 August 2002 and before he gave evidence on 25 September 2002. The Schedule is of the type which I would have expected would have been prepared as part of the planning processes before the trip, not as an after thought because there had been a fatal accident. In the Schedule the issues have been identified and addressed. Without such a Schedule I ask the question as to how I can be satisfied that the issues have been previously addressed

by the School Teacher. I cannot be so satisfied apart from taking the word of Mr Kowalewski that they were addressed.

The thrust of the cross examination of Mr Kowalewski by Mr Callendar on behalf of the family of the deceased was to examine whether or not proper and safe procedures were in place at the time when the students were on the mountain. Mr Kowalewski gave evidence that he had taken trips to the mountain previously, the last trip being the year before. The difference from that trip and the trip in 2001 was the addition of a ski lesson. The lesson was included to improve the skiing skills of the students which in turn would improve safety. Whilst the students were taking the skiing lesson Mr Kowalewski went up the mountain to check on conditions for himself. He left no one in charge of the students in his absence. He left no instructions as to what was to happen at the end of the lesson because he understood the lesson to be of one hour duration and he expected to be back from the reconnaissance of the mountain before the lesson ended. Either the lesson was of a shorter duration than one hour or Mr Kowalewski took longer than one hour because by the time he had returned the lesson was over and the children had dispersed. In his absence I consider it would have been reasonable to expect him to have given instructions to the other adult supervisors as to what was to happen after the lesson finished. Mr Kowalewski intended to return from his reconnaissance to advise all of the students and the adult supervisors as to what was to happen thereafter. In his reconnaissance Mr Kowalewski quickly discovered that only the Movenpick chairlift was working on that day and as a result the students if using the chairlift would not be restricted to what he understood was the stipulated area to be used by these students carrying lower mountain passes, which passes had been issued to his school group. By way of the Movenpick chairlift the students could go further up the mountain which may mean danger to them depending upon their skiing ability. Having discovered this as the situation I believe Mr Kowalewski should have returned to the students at the ski lesson area and worked out a plan with the assistance and cooperation

of the other adult supervisors to endeavour to restrict the area of skifield to which the students had access to. This did not happen. Mr Kowalewski had not anticipated that only the Movenpick chairlift was working. His expectation was that the Parklane chair would have been operating as well and provided the children had been given a direction to use the Parklane chairlift only then this would have restricted the students to the lower and potentially less dangerous parts of the ski field area. Mr Kowalewski was of the belief that the lower mountain pass would also restrict students access to the lower mountain area only but quite clearly from the evidence heard this was not the position at all. Perhaps Mr Kowalewski did not make the right enquiries or ask the right questions in his planning for the trip. He took it for granted that the lower mountain pass restricted access to certain parts of the skifield only. The situation from last year was quite different in that in the previous year the weather was so bad that the students were restricted to the lower mountain so this was not an issue he had encountered before.

Having returned from his reconnaissance up the mountain, Mr Kowalewski found the lesson over and the students had dispersed. The students had not been organised into specific groups with a nominated adult supervisor. Given the favourability of both weather and snow conditions that day, Mr Kowalewski concluded that the students would be adequately supervised by the fact "that the children had been instructed to stay in groups within the areas they were skiing and that the presence of the adults in the areas, both skiing and non-skiing would provide adequate supervision" (page 74/75 of the evidence notes). Mr Kowalewski explained why he did not find the specific groups/nominated adult supervisor approach appropriate. Mr Kowalewski preference for supervision was based on the fact that access would be restricted to the lower mountain area but by his own reconnaissance he had found that this was not possible given the Parklane Chair was not working and the Movenpick chairlift had the ability to take students above the lower mountain area. In addition he was under the misapprehension that the passes issued to the children on the

day would restrict access.

Mr Kowalewski had not had the opportunity to inform the students of any restrictions which would apply because they had already dispersed by the time he returned. He had decided to inform the students of his plans on that day rather than to brief them at the Lodge the night before because in his evidence many of the children had not been to the mountain before and to describe to them where they could go would not mean anything to them (page 73 of evidence notes, no. 17). I do not agree with this approach. Prior planning and instruction to the students would have better informed them that it was the Parklane Chair which they should be using so when those students wanting to access higher up the mountain found that the Parklane Chair was not working then they may have enquired of an adult supervisor if they could use the Movenpick chairlift. In the knowledge this chairlift would take the students higher up the mountain then this may have resulted in checks being put in place on the day to stop the children going any higher than the Wintergarden ski area.

I understand the skiing lesson was added as a safety reason. The lesson would have given an insight into the skiing skills of each of the students. Obviously the ski skill level differs from one student to the next. The lesson was taken by a Ski Instructor employed by Ruapehu Alpine Lifts. That Instructor would have been able to judge the skill or ability of each student by what he observed in the course of the lesson. The same could be said of those adult supervisors with skiing experience accompanying the school trip including Mr Kowalewski. They could observe the students and decide what level of skill each of the students had. They could have then issued instructions to each of the students as to the ski area in which they could ski on the mountain, thereby reducing the risk of injury or accident. In fact Mr Kowalewski did not observe the skills of any of the students at the ski lesson because he was absent on the reconnaissance. He did not instruct any of the other adult supervisors or teachers

present to observe and categorise the students according to their skill level. There is reference to this type of approach in the Hillary Commission Periodical on Outdoor Pursuits where there is reference to guidelines including the proposition that the students are observed, grouped by leaders according to needs and ability levels and the required terrain at the beginning of the activity. This did not happen on this occasion.

Sadly in my opinion there were a number of errors and omissions by Mr Kowalewski not only on the mountain that day but also in the preparation for the trip. I believe these errors and omissions were an oversight on his behalf, a lack of thought, and a lack of full and proper planning on his behalf. I am not satisfied on the evidence that all procedures required in relation to planning, hazard management, risk management and supervision ratios were completed prior to the activity to ensure the students were in a safe environment.

The purpose of an Inquest is two fold. This Court is to establish as far as possible the fact of death, the identity of the deceased, when and where the death occurred and the cause and circumstances.

As to those matters I am satisfied that Matthew Phillip Brown died on the 14th day of September 2001 as a result of grievous traumatic injuries to the lungs and head which injuries were received when he fell whilst skiing in the Wintergarden Ski Area, Turoa Skifield, Mount Ruapehu. The circumstances of his death was that he had been skiing, had lost control crashing onto rocks, suffering the fatal injuries.

The first purpose for an Inquest has therefore been achieved.

The second purpose of an Inquest is however to enable a Coroner to make recommendations or comments on the avoidance of circumstances similar to those in which the death occurred, or in the manner in which persons should act in such circumstances

that in the opinion of the Coroner, may if drawn to public attention, reduce the chances of the occurrence of other deaths in similar circumstances.

The impossibility of protecting all people from all dangers in the outdoors is obvious. However this Inquest has shown that there were flaws in the planning and implementation of the plan for this particular school trip.

These are:-

1. A failure by the School to follow its own EOTC policy. I am not satisfied on the evidence:-

    (a) that the trip was granted prior approval by the Principal. In fact a prior approval for the previous year's ski trip may have been relied upon as approval for this trip.

    (b) that the Principal had allocated appropriate ratios of adult supervisor to numbers of students. This is not to say that the issue of ratios was not considered or addressed. The Policy specifically provides for the Principal to allocate appropriate ratios and there is no evidence of this.

    (c) that all procedures required in relation to planning, hazard management, risk management and supervision ratios were completed prior to the activity. Mr Kowalewski identified what issues were pertinent. The only evidence to say these issues were addressed was his verbal evidence to the effect that I would have to take his word for it. Having identified the issues I consider a Schedule such as Exhibit 21 should have been drawn up so as before approval is given for such a trip the person approving the trip (who in this instance according to the School Policy would have

been the Principal) is satisfied the issues have been identified and properly addressed.

(d) Further I find that the role of the Director of Daily Resources is not defined in the Policy or Guidelines.

(e) I am uncertain as to the role of the Board of Trustees as regards the EOTC policy. The overall responsibility of the School vests in the Board but its role is again not defined but Mr Kowalewski said in his evidence that BOT approval for the trip was obtained, but I believe this approval was a flow on from the approval given the previous year.

The School needs to review and update its EOTC policy and guidelines. I have reached this conclusion on the evidence tendered to me at the Inquest. I observe the School was represented by Counsel and had the opportunity to put evidence to me if it wished to do so.

2. As regards the planning, preparation and what happened on the day I am not satisfied all that could have been done was done to ensure the safety of the students on this ski trip. There were errors and omissions. I have already highlighted earlier in this decision my concerns (see pages 6 to 9). I do not intend to dwell on them further.

This Inquest has shown how improvements could be made to reduce the potential of another fatal accident.

In all EOTC activities it would be reasonable to expect that:

(a) all adult supervisors whether they be teachers other school staff or volunteer family members be familiar with the other, have a clear understanding of their obligations on the trip, what is expected of them, what the plan is and how the plan is to be implemented

and have an established chain of command as part of their group.

(b) when the leader of the group is absent for whatever reason that there is a designated person in charge which person takes control and implements the plan which that person is thoroughly familiar with. This understanding and knowledge would come about from meetings at school as part of the planning process for the trip, from written material provided by the leader in charge to the adult supervisors as to his expectations of them, and from instructions conveyed by the leader to the second in charge on the day given with skiing in particular conditions can change, at very short notice.

(c) there be a thorough knowledge of the conditions prevailing and the facilities available on the day and that knowledge is passed on to the students before they embark on the activity in which they are to be involved.

(d) when the activity is skiing that the students be observed at the ski lesson and if possible, with the assistance of the Ski Instructor and/or other experienced adult supervisors, be categorised as to competency and skill so as they are less likely to be exposed to greater risk or danger.

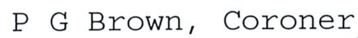
(e) careful consideration be given as to the best option for providing supervision to the children. This will depend upon the activity in which they are involved. There is the approach supported in the Periodical from the Hillary Commission against the approach adopted by Mr Kowalewski on the day. The single most important factor in determining the approach to be followed for the activity in question is the safety of the

children.

I recommend the School review its EOTC Policy to incorporate these recommendations.

I am obliged to Counsel and the Police for their assistance.

Lastly I offer my condolences to members of Matthew's family and express the hope that the lessons learnt as a result of his death may prevent deaths in similar circumstances in the future.



P G Brown, Coroner
18/10/02