

**Australian Camps Association response to the Coroner's Report on the death of Kyle Vassil at Alpine Ash Retreat on February 17th, 2010.**

*Court Reference Number: COR 2010 000661*

The Australian Camps Association (ACA) notes the findings and recommendations of Coroner Peter White resulting from his inquest into the tragic death of year 7 Aquinas College student Kyle Vassil at Alpine Ash Retreat in February 2010.<sup>1</sup>

The ACA is dedicated to supporting Camp and led outdoor activity providers to adhere to the highest standards of quality service provision, most particularly in the area of risk management.

Central to the ACA's current efforts in this area is the facilitation of the UPLOADS<sup>2</sup> project. UPLOADS (Understanding and Preventing Led Outdoor Accidents Data System) is a research partnership between the Led Outdoor Activities sector across Australia and the University of Sunshine Coast Accident Research (USCAR) team to develop and implement an evidence based accident analysis methodology and incident reporting system for the led outdoor activity sector with the aim of reducing accident rates.

In order to provide a more detailed context for the implementation of Coroner White's recommendations, the ACA commissioned an analysis of the Coroner's report by Professor Paul Salmon and Dr. Natassia Goode, leaders of the UPLOADS project at USCAR.

Extracts from the USCAR report are included below. For the Coroner's interest and reference, a full copy of the USCAR report is include below as Appendix 1.

We believe that the Coroner's findings and recommendations in support of improving risk management and crisis response planning, when implemented, will support a reduction of preventable deaths during Camps and Led Outdoor Activities (LOA). We think that they are relevant throughout Australia and beyond.

It is evident in the details of the Coroner's report and the obvious and necessary limitations on the scope of all such investigations, that it is incumbent upon Camp and LOA providers to contextualise the recommendations and seek to apply them in ways that take full account of

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<sup>1</sup> Coroners Court of Victoria (2014). Finding – Inquest into the death of Kyle William Vassil, COR 2010 0661, State of Victoria, Published October 2014, [http://www.coronerscourt.vic.gov.au/resources/235cee6c-4ed6-4d07-b62c-c85097d669e3/kylewilliamvassil\\_066110.pdf](http://www.coronerscourt.vic.gov.au/resources/235cee6c-4ed6-4d07-b62c-c85097d669e3/kylewilliamvassil_066110.pdf)

<sup>2</sup> UPLOADS - Understanding and Preventing Led Outdoor Accidents Data System <http://uploadproject.org/>

the nature and scope of the activities of the outdoors sector, its regulatory environment and resourcing parameters.

The Coroner's report makes six recommendations. The first three of these are aimed at influencing all non-Government schools to adopt the Victorian Department of Education and Training's (DET, formerly DEECD) Safety Guidelines for Education Outdoors (SGEO)<sup>3</sup>. Recommendations 4 and 6 encourage schools and Camps to acquire and ensure staff are trained in the use of defibrillators. Recommendation 5 urges Catholic schools to acquire appropriate safety equipment for swimming activities.

On the basis of Coroner White's recommendations and the USCAR team's detailed analysis, the Australian Camps Association has determined to undertake a number of actions.

***Coroner's recommendations 1, 2 & 3 - all non-Government schools should adopt the Victorian Department of Education and Training's Safety Guidelines for Education Outdoors:***

The ACA agrees with the Coroner's opinion that the Victorian DET Safety Guidelines for Education Outdoors offer a sound approach to managing risk in Led Outdoor Activities. However, their direct adoption by non Government schools and Camp and LOA providers is not an ideal or sustainable solution due mainly to issues of jurisdiction and ownership.

Although the current iteration of the DET SGEO were developed through a consultative process, drawing on the expertise of LOA practitioners from across the sector, the DET holds no responsibility toward organisations outside its jurisdiction, has no obligation to provide services to them or to consult with them and has no capacity or authority to enforce compliance.

The ACA notes that the Coroner made no reference in his report to the Victorian Adventure Activity standards<sup>4</sup> or to Camps accreditations programs<sup>5</sup>, all of which include guidelines on risk management and which are broadly utilised beyond the scope of the DET. We further note that no compliance enforcement mechanism exists under these or any other current risk management guidelines for the LOA sector. This may be an area for further consideration by the Coroner and by Government.

The salient strength of the SGEO which appears to have provided the Coroner in this case with such an excellent reference point, is that it is centred and founded on the principles of the international standard on risk management, ISO 31000. This standard places the rigorous

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<sup>3</sup> <http://www.education.vic.gov.au/school/principals/health/Pages/outdoor.aspx>

<sup>4</sup> [http://outdoorsvictoria.org.au/activity\\_standards.php](http://outdoorsvictoria.org.au/activity_standards.php)

<sup>5</sup> <http://www.atapvic.net.au/specaccredprog.php>

assessment and mitigation of risk, along with continuous and effective communication, at the centre of risk management thinking and practice.

Whilst the DET SGEO do indeed offer an excellent interim reference point for non Government schools and Camps to manage risk, a more sustainable and effective solution will be to align and reconcile the other extant LOA guidelines, regulations and practices, including Adventure Activity Standards and Camps accreditation systems, with the standards based approach embodied in the DET guidelines.

We understand that the Coroner's recommendation for non-Government schools to adopt them is based on several key features of the DET Guidelines:

- The central emphasis on thorough risk assessment
- The presence of comprehensive guidelines on assessing and managing risk in recreational swimming
- Emphasis on appropriate training and experience of supervisory staff
- Effective crisis response planning
- A standards based approach to managing risk

Although the Coroner's recommendation 1 specifically advocates the adoption of the DET Guidelines for "...school student swimming and related water based sporting activity...", recommendation 2 and the Coroner's comments in sections 301 - 303 of his report, along with his comments in footnote 141, all suggest the adoption of such an approach for the planning and conduct of all Led Outdoor Activities for school students. Furthermore, it is evident that several of the critical areas that the Coroner found to be in need of improvement - risk assessment, crisis response planning, staff training and experience - are relevant to the planning and conduct of all Led Outdoor Activities, not just swimming.

The ACA finds it noteworthy that the ratio of supervisory staff to participants was not found to be a factor in this incident (indeed, the ratio reported in evidence to the Coroner exceeded DET Guideline minimum requirements), but that the nature of the supervision provided was a more salient factor. This circumstance adds weight to ongoing expert opinion that an over reliance and over emphasis on supervisory ratios as the primary factor in LOA risk mitigation is misplaced and potentially counter productive.

*Observations from USCAR<sup>6</sup>:*

"Overall, the analysis presented supports the recommendation that improved policies and procedures relating to water activities and risk assessment are required.

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<sup>6</sup> From the USCAR report, "USCAR Analysis of Coroners Report on Kyle Vassil death", Salmon & Goode, 2014

However, while extensive, the DEECD guidelines have not been subjected to empirical evaluation.

Further, while the guidelines are available on the DEECD website, significant work will need to be undertaken to disseminate this information throughout the sector.

The analysis also highlights that simply adopting the DEECD guidelines will be insufficient to prevent future accidents. Extensive training is required to ensure that Principals and teachers understand how to implement the protocols, especially those relating to risk assessment and control. Potentially, a training package could be developed that enables practical support in implementing these guidelines.

Finally, this recommendation does not address the risk assessment procedures and policies implemented by the Camp Manager. The analysis highlights that the Camp Manager was not fully aware of the risks posed by the dam, or ensured that school groups had appropriate controls in place. This implies that ACA members need more training in hazard identification and risk assessment. The interactions between the contributory factors imply that schools and Camps need to work more closely together to ensure that risks are appropriately identified and managed.”

*In keeping with recommendations 1, 2 and 3, the ACA will:*

- Encourage ACA members to adopt and apply ISO 31000 compliant risk management practices
- Offer training in standards based risk assessment methodology
- Offer training in the development of effective critical incident response plans
- Encourage members to become familiar with the DET SGEO
- Support and encourage the reform of Adventure Activity Standards (AAS) to more closely align them with the DET SGEO
- Support and encourage the reform of risk management components of Camps accreditation systems to more closely align them with the standards based approach to risk management
- Advise and advocate to Government and its agencies to encourage the adoption of ISO 31000 principles by LOA providers

***Coroner’s recommendations 4 & 6 - schools and Camps to acquire and ensure staff are trained in the use of defibrillators:***

Whilst the ACA is of the view that the major focus of risk management improvement should be in the area of accident prevention, we acknowledge and support the need to continuously

monitor and improve approaches to critical incident (emergency) response. We note the recommendations of St John Ambulance Australia, the Australian Resuscitation Council and the National Heart Foundation of Australia on early access to defibrillation<sup>7</sup>

*Observations from USCAR<sup>8</sup>:*

“While the inquest did not provide evidence that a defibrillator would have prevented Kyle Vassil’s death, there is significant empirical evidence that the immediate use of these devices contributes to fatality prevention.

However, purchasing a defibrillator should not be considered to be a risk control strategy for swimming activities. Using a defibrillator will only potentially minimize harm once an adverse event has occurred; the risks associated with swimming remain.

The analysis does raise questions about crisis response procedures, and whether teachers and Camp Managers need training in crisis response. It is evident from the analysis that a number of factors contributed to the poor coordination of the search and the difficulty in conducting the diving search systematically. Most prominently, the lack of a crisis response plan contributed to communication difficulties between key actors, and a poor understanding of teachers’ responsibilities in the event of a crisis. These issues are pertinent not only for swimming activities, but for any activity in the outdoors.”

*In keeping with recommendations 4 and 6, the ACA will:*

- Recommend that Camps purchase defibrillators and ensure that staff are trained in their use
- Investigate and consider how the ACA may be able to encourage schools to adopt this recommendation

***Coroner’s recommendation 5 - Catholic schools to acquire appropriate safety equipment for swimming activities:***

In keeping with the best available research, the ACA supports the notion that the availability and use of appropriate equipment is one of several critically important and interconnected components of effective risk management in Led Outdoor Activities.

*Observations from USCAR<sup>9</sup>:*

“While the inquest did not provide evidence that swimming safety equipment would have prevented Kyle Vassil’s death, it is clear that the provision and use of such equipment would

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<sup>7</sup> <http://www.heartfoundation.org.au/SiteCollectionDocuments/EAD-joint-statement-2012-update.pdf>

<sup>8</sup> USCAR, Op Cit

<sup>9</sup> USCAR, Op Cit

assist in preventing water-related injuries and fatalities. This recommendation is appropriate, however, again caution is urged. In particular, the purchase of equipment alone will not remove the many other contributory factors identified.”

*In keeping with recommendations 4 and 6, the ACA will:*

- Recommend that where appropriate, Camps are equipped with the relevant equipment to support emergency response plans for swimming (and all other) activities
- Investigate and consider how the ACA may be able to encourage schools to adopt this recommendation

Finally, the Australian Camps Association will continue to support and facilitate research into prevention of led outdoor activity accidents and work to translate the findings of that research into reforms of practice. We will continue our ongoing efforts toward increasing consistency and simplicity in approaches to managing risks across and within all of the levels at which risk is managed in Camps and Led Outdoor Activities.

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'David Petherick', with a large loop at the end.

David Petherick  
Chief Executive Officer  
Australian Camps Association  
1/14 Concorde Dve.  
KEILOR PARK VIC 3042

## **Appendix 1:**

### **USCAR Analysis of Coroners Report on Kyle Vassil death**

*Paul Salmon and Natassia Goode*

#### **Introduction to our work in the sector**

The Australian Camps Association, Professor Paul Salmon and Dr Natassia Goode have been engaged in a research alliance focused on injury prevention in the Led Outdoor Activity (LOA) sector since 2008. The aim is to develop new and improved systems for understanding and preventing injuries during led outdoor activities, with the long term impact being safer led outdoor activities across the sector.

The first stage of the collaboration involved a literature review on incident causation in led outdoor activities and a case study analysis of selected led outdoor activity accidents (see Salmon et al, 2009; 2010). The outcomes of this research were the impetus for the development of a large-scale injury surveillance project, which is currently funded through an Australian Research Council Linkage Grant and LOA provider contributions.

As part of this research program we have developed an incident reporting and learning system for the LOA sector, known as UPLOADS (Understanding and Preventing Led Outdoor Accident Data System). UPLOADS provides LOA providers with a means of reporting and analysing injury and near miss incidents for the first time in Australia. The innovation lies in the ability of UPLOADS to collect data on the system-wide causes of injuries, such as factors relating to government policy and funding, regulation, company management and supervision, as well as factors relating to workers, equipment and the environment. In addition, UPLOADS enables identification of the relationships between causal factors, allowing it to go beyond what is typically captured by incident reporting systems, providing a far greater description of incidents. UPLOADS has recently been implemented by over 40 LOA providers as part of a year-long national trial.

The system itself is underpinned by a systems-theory model of accident causation, Rasmussen's (1997) Risk Management Framework (RRMF). Rasmussen's framework is underpinned by three key principles.

First, safety is impacted by the decisions and actions of everyone in the led outdoor activity system, not just instructors, teachers and participants. This includes those working at the upper levels of the system such as activity centre management, regulatory bodies, and government.

Second, near misses and adverse events are caused by multiple, interacting, contributing factors. Accidents do not occur because of one bad decision or action alone, they are created by the interactions of multiple decisions and actions across the led outdoor activity system. It is meaningless, therefore, to attempt to understand accidents by searching for a 'root cause'.

Third, improving safety through countermeasures can only be achieved through systemic change. Fixing individuals or equipment does not work. The goal of UPLADS is therefore not to assign blame to any individual, but to identify how factors across the led outdoor activity system combine to create incidents.

The research team has adapted RRMF to describe the “led outdoor activity system” as a hierarchy comprising multiple levels including:

- government policy and budgeting;
- regulatory bodies and associations;
- activity centre planning, management and budgeting, local area government, parents and schools; technical and operational management;
- supervisory and management decisions and actions;
- physical processes and instructor/participant activities; and
- equipment and surroundings.

LOA accidents are therefore caused by the interaction of decisions and actions at each of the levels specified above. This framework has been validated through the examination of case studies of fatal led outdoor activity incidents, such as the Mangatepopo and Lyme Bay incidents (Salmon et al., 2012; Salmon et al., 2010) and also less severe injury incidents occurring during led outdoor activities (Salmon et al., 2014).

### **A systems description of the Kyle Vassil incident**

Kyle Vassil died after becoming submerged while swimming in a dam whilst attending a school camp with Aquinas Secondary College near Kinglake in February 2010. Coroner Peter White recently released the findings from an inquest into the incident (Coroners Court of Victoria, 2014). The aim of the work presented in this report was to apply RRMF to the findings presented in the Coroner’s report, with a view to:

- 1) Understanding the findings from a systems perspective (i.e. identifying the system-wide contributory factors involved along with the relationships between them);
- 2) Evaluating the Coroner’s recommendations in light of the systems analysis; and
- 3) Identifying what Australian Camps Association members, and the LOA sector as a whole, can learn from Kyle Vassil’s tragic death.

### **Methodology**

RRMF provides the Accimap methodology for describing events through a systems lens. Accimap is used to graphically depict the decisions, actions, and conditions that interacted with each another to produce the accident in question. Contributory factors at each of the system levels are identified and linked between and across levels based on cause-effect relations.



The authors used Accimap to describe the findings presented in the Coroner's report. Each author independently reviewed the Coroner's report to identify the contributory factors involved and the relationships between them. To be extracted from the report, the contributory factors and relationships had to be explicitly stated within the report (i.e. researchers were not allowed to draw inferences about the existence of factors or relationships between factors, such as murky water and visibility). Following this, the researchers then came together to discuss the contributory factors identified and arrive at a consensus on them as well as the level at which they should be placed in the Accimap. At this stage any disagreements were resolved through discussion until consensus was met.

The researchers then examined the contributory factors to identify relationships between contributory factors that were *implied* by the report. These relationships were not explicitly stated, but the circumstances implied that the links potentially existed. For example, a relationship was identified between the dam floor being slushy and black and the poor visibility in the water. Another example is the relationship between the camp coordinator's co-ordination of the supervisory responsibilities at the dam, and the poor supervision of the swimming activity. Identification of these relationships allows a better understanding of *why* certain failures occurred, and *why* certain actions and decisions seemed rational at the time. Moreover, it is well known in safety science circles that accident causation can only be understood by focusing on the interactions between contributory factors.

## **Results**

The Accimap describing the contributory factors and relationships that were deemed to play a role in the Kyle Vassil incident is presented in Figure 1.

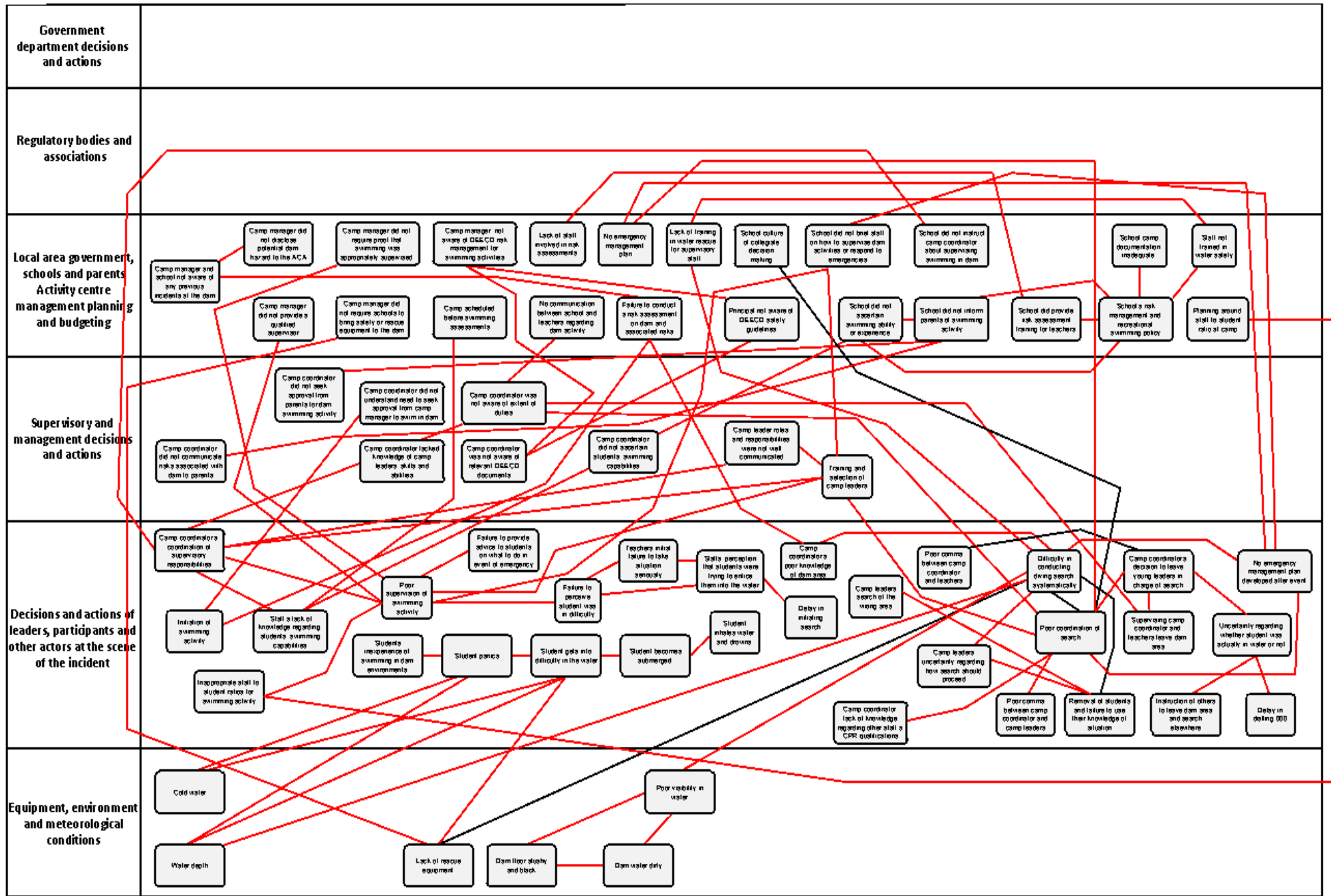


Figure 1. Accimap showing contributory factors and the relationships between them; note, relationships shaded in black are those that were explicitly stated in the Coroner's report and also identified by the authors. Relationships shaded in red are those identified by the authors.

### **What does the analysis tell us?**

The aim of this study is not to attempt to identify new evidence or contributory factors relating to Kyle Vassil's death; rather, the aim is to view the Coroner's findings through a systems lens. In this context, the Accimap description presented in Figure 1 provides some clear findings regarding the causal nature of Kyle Vassil's tragic death.

First, the Accimap shows that there were multiple contributory factors involved in creating the incident. As shown in Figure 1, over 60 contributory factors were identified across the led outdoor activity system. These contributory factors were identified at the following levels:

- Local area government, schools and parents, activity centre management;
- Supervisory and management decisions and actions;
- Decisions and actions of leaders, participants, and other actors at the scene of the incident; and
- Equipment, environment and meteorological conditions.

Moreover, the contributory factors relate to multiple people, organisations and artifacts within the system, including the dam itself, the participants, the camp coordinator and camp leaders, the camp manager, and the school principal. The conclusion to take from this is that the Kyle Vassil tragedy was indeed a 'systems' accident. No one individual within the led outdoor activity system was responsible; rather, there was a shared responsibility for the incident spanning the led outdoor activity system. This is consistent with our understanding of accident causation, both in the led outdoor activity context and safety critical domains generally.

It is worth noting that contributory factors were not identified at the top two levels of the system (Government department decisions and Regulatory bodies and associations). It is our opinion, however, that this does not suggest that higher-level factors were not involved, rather, it is representative of the levels focused on by the Coroner. For example, the Coroner's recommendation that there be sector wide adoption of the DEECD's safety guidelines raises questions regarding the role of other regulatory bodies. A recommendation for future Coronial investigations is therefore that the role of regulatory and government agencies be explicitly examined.

Second, the relationships shown in Figure 1 provide insight into why certain decisions, actions or omissions seemed rational and appropriate at the time. For example, the school may not have conducted a risk assessment on the swimming activity because the camp manager had not experienced any incidents associated with the dam in the 50 year history of the camp. Another example relates to the coordination of the search. The school did not provide any training on water safety or guidelines on emergency management, therefore the camp coordinator and teachers did not formulate a search strategy immediately after Kyle's disappearance. These findings again emphasise the importance of focusing on relationships between contributory factors when examining adverse events. Further, it raises questions

regarding the extent to which the description of the tragedy provided in the coroners report reflects the complex and systemic nature of the incident's causes. The majority of the relationships identified between contributory factors were identified by the authors and are not explicitly acknowledged or discussed in the coroners report. In our opinion this represents a critical oversight – it is well known in safety science circles that the relationships and interactions between contributory factors are more important than the contributory factors themselves when attempting to understand and prevent accidents. A failure to consider these relationships leads to a limited understanding of how accidents happen, and more worryingly, can often promote a blame culture in that key events are attributed to individuals and their own behaviour rather than interactions between factors and the resulting impact on behaviour. A recommendation for future Coronial investigations is therefore that there should be an explicit focus on identifying the relationships between different contributory factors.

In terms of the nature of the contributory factors involved, a third important finding is that there were a number of contributory factors surrounding organisations' policies, programs, and processes. For example, issues relating to risk assessment, training programs, emergency management plans, and activity planning were identified. The strong message from this finding is that more explicit consideration of injury and risk controls is required when organisations are training staff, developing activity programs, and planning for LOAs. Importantly, this recommendation applies across stakeholders, including LOA providers, camp owners, and schools. Risk management is something that has to occur at all levels of the LOA system.

Fourth, in addition to the contributory factors that emerged on the day of the incident, many occurred or emerged in the days, weeks and/or months preceding it. For example, factors related to the school's teacher training programs, risk management processes and communications with the activity centre were identified. Similarly, factors relating to the camp's policies and awareness of risk management guidelines were noted. These represent contributory factors that played a role some time before the incident itself. Again, this finding emphasises the importance of adopting good safety and risk management practices during activity planning and preparation as well as during the activity itself. In short, LOA risk factors are not only present during the conduct of the activity.

A fifth important finding is that many of the contributory factors identified relate to inadequate communication. Critically, these communication issues were present both within and across levels of the led outdoor activity system. For example, although not mandated for the school or activity involved, various actors were not cognizant of the DEECD guidelines; parents were not aware that there was going to be a dam swimming activity; and camp leader roles and responsibilities were not well communicated to them. A key feature of communications failures is that it is not just all about people not talking to one another; often it is poor communication within documentation, policy and procedures, training programs, risk management and equipment. In this case, for example, poor communication of the DEECD guidelines relates not only to communications between people but also to the

documentation itself and how readily accessible it is. A recommendation from this finding is therefore that stakeholders need to consider what needs to be communicated in relation to risk management who needs to know it, and what or whom should be communicating the information. Only then can they identify where these 'communication' issues exist and fix them. It is also important to note that effective communication is required both within and across the LOA levels specified.

A sixth important finding is the dual role that some contributory factors played, both in creating the incident, and then in hindering the response to the incident. For example, the environmental factors that contributed to Kyle Vassil's difficulty in the dam, were also those that hindered the search. Similarly, poor communication of camp leader roles and responsibilities impacted their supervision of the activity as well as the coordination of the search.

Finally, it is worth considering contributory factors that may have been overlooked. One potential oversight is the role of the accreditation system and also further examination of the camp's procedures and risk management processes may have been pertinent.

### **Evaluation of Coroner's recommendations in light of the analysis**

Before examining the Coroner's recommendations it is worth commenting on the difficulties associated with recommending and developing countermeasures in response to injuries and fatalities. It is now well understood within safety science circles that there is never one specific contributory factor that, on its own, is responsible for an accident. As described above, accidents are a highly complex phenomenon. They are caused by multiple interacting factors across the overall system of work.

This makes providing suitable recommendations and developing countermeasures highly difficult. It is dangerous for organisations to think that there are a few changes they can make to prevent future accidents. There is no silver bullet. A good example of this is the typical response that involves fixing or purchasing new equipment. Whilst this (in most cases anyway) improves the resources available to staff, it does not address *why* equipment failed in the first place. For example, factors such as competing financial pressures, a limited allocation of funding for equipment maintenance, policies around replacing equipment, equipment maintenance procedures, the absence of lines of communication around broken equipment, training that doesn't cover inappropriate usage of equipment etc. When the new equipment arrives, all of the other factors still remain in the system, and the new equipment eventually returns to its unsafe state.

This fixing broken components approach is accepted to be a flawed approach to safety management (Dekker, 2011). Rather, recommendations for countermeasures should focus on the overall system and the interactions between contributory factors. The appropriate approach is instead to focus on the system and the factors that interact to influence risk and safety. Typically, these factors reside at the upper levels of the system away from the immediate context of accidents themselves.

We therefore urge caution in focusing on components, and instead call for systemic examination and change based on the findings discussed earlier. It is with this caveat in mind that we discuss the Coroner's recommendations below.

Following his findings the Coroner made 6 recommendations surrounding the DEECD safety guidelines, defibrillators, and swimming safety equipment.

#### *Sector wide adoption of DEECD Safety Guidelines*

Overall, the analysis presented supports the recommendation that improved policies and procedures relating to water activities and risk assessment are required.

However, while extensive, the DEECD guidelines have not been subjected to empirical evaluation.

Further, while the guidelines are available on DEECD website, significant work will need to be undertaken to disseminate this information throughout the sector.

The analysis also highlights that simply adopting the DEECD guidelines will be insufficient to prevent future accidents. Extensive training is required to ensure that Principals and teachers understand *how* to implement the protocols, especially those relating to risk assessment and control. Potentially, a training package could be developed that enables practical support in implementing these guidelines.

Finally, this recommendation does not address the risk assessment procedures and policies implemented by the camp manager. The analysis highlights that the camp manager was not fully aware of the risks posed by the dam, or ensured that school groups had appropriate controls in place. This implies that ACA members need more training in hazard identification and risk assessment. The interactions between the contributory factors imply that schools and camps need to work more closely together to ensure that risks are appropriately identified and managed.

#### *Purchase of defibrillator by schools and Australian Camps Association members*

While the inquest did not provide evidence that a defibrillator would have prevented Kyle Vassil's death, there is significant empirical evidence that the immediate use of these devices contributes to fatality prevention.

However, purchasing a defibrillator should not be considered to be a risk control strategy for swimming activities. Using a defibrillator will only potentially minimize harm once an adverse event has occurred; the risks associated with swimming remain.

The analysis does raise questions about crisis response procedures, and whether teachers and camp managers need training in crisis response. It is evident from the analysis that a number of factors contributed to the poor coordination of the search and the difficulty in conducting the diving search systematically. Most prominently,

the lack of a crisis response plan contributed to communication difficulties between key actors, and a poor understanding of teachers' responsibilities in the event of a crisis. These issues are pertinent not only for swimming activities, but for any activity in the outdoors.

#### *Purchase of swimming safety equipment by Catholic Schools and Australian Camps Association members*

While the inquest did not provide evidence that swimming safety equipment would have prevented Kyle Vassil's death, it is clear that the provision and use of such equipment would assist in preventing water-related injuries and fatalities. This recommendation is appropriate, however, again caution is urged. In particular, the purchase of equipment alone will not remove the many other contributory factors identified.

#### **What can Australian Camps Association members learn from this accident to inform their practice?**

It is critical that there is an appropriate response to the Coroner's findings from Australian Camps Association members and the sector generally. A lasting legacy of Kyle Vassil's tragic death is that it could help change the LOA system for the better along with the way in which the sector responds to such incidents in future.

In the aftermath of catastrophic events there is often a strong desire to fix the one thing that is seen as the major cause, which in turn often facilitates a focus on the individuals closest to the incident (e.g. camp co-ordinators, leaders, participants). As mentioned, however, it is dangerous to think that there is one thing, one silver bullet that will prevent future incidents. In addition, it is morally and ethically wrong to blame individuals for this tragic event. Accidents are something that are caused by systems, not by individuals. The right approach is fundamental change rather than component fixes – there needs to be a system of countermeasures that deals with contributory factors across the entire LOA system.

With this in mind, there are a number of things that can be addressed. For example, those involved in planning and running activities can develop processes, policies, and practices that facilitate questions around the safety of activities and venues. For example:

- Has there been appropriate communication between the parties during activity planning? This includes participants, leaders, supervisors, camp managers, school teachers, and parents;
- What hazards exist at the venue and do they change with the conditions?
- Is the level of risk associated with each hazard appropriate for groups using the venue to manage on their own?
- Are the groups overseeing the activity aware of these hazards, and what controls do they have in place to control the risks associated with them?

- Do we need to provide any resources to these groups to help them minimize the risks?
- What are the responsibilities of different people related to risks and their management? What are the responsibilities in the event of an emergency?
- Who is responsible in the event of an emergency? What happens if that person is offsite?
- Do we have a crisis response plan? Are all staff aware of the plan? Has everyone had crisis response training?

### **What does it mean for the sector over next 20 years?**

The analysis implies that the sector needs to work towards agreed upon standards, guidelines and procedures for safety management for groups using camps, and for camps themselves. Safety management systems need to encompass both risk management and crisis response.

For groups using camps, these standards, guidelines and procedures should include tools for assessing the risks associated with outdoor programs and implementing appropriate controls. Good risk assessment and management tools will not only identify risks, but also outline the roles and responsibilities of all actors within the system. Understanding one's responsibilities and communicating effectively with other actors is key to maintaining safety within outdoors programs.

At the camp level, safety management systems should primarily focus on providing a safety net for the groups using their venues. Part of this will involve assessing and controlling risks before groups arrive, and part of this will involve communicating risks to groups, and evaluating the risk controls they have in place. Again, making sure that all staff understand their responsibilities with regards to risk control is critical.

Finally, our examination of the Coroner's findings shows a number of communication failures, as previously noted. It seems likely that the various people involved in planning and supervising the Aquinas camp had different understandings both of how to assess and manage risk and of their responsibility in doing so. The conceptual frameworks that inform approaches to managing risk at various levels across the LOA system, vary widely. Adventure Activity Standards and Education Department guidelines in each State and Territory, accreditation systems, instructor and manager training and organisational approaches have all been observed to lack a coherent and consistent approach to risk management and accident prevention.

It is in the interests of the LOA sector and those it serves to work toward increasing consistency and simplicity in approaches to managing risks across and within all of the levels at which risk is managed. A system of risk management is required that consistently deals with risks at all levels of the LOA system.

### **Acknowledgements**



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