

Lessons learned when rafted canoeing goes wrong

September 2006

Issue

A group of middle managers were on a team building exercise which involved an open water crossing of about one and a half miles, close to but not across a deep tidal shipping channel. They were using two open canoes, rafted together with wooden spars, believing this would allow more challenging journeys with less experienced paddlers.

Background

As the team worked their way through their written brief for the exercise, watched over by an instructor in a small rib, and by a third party 'facilitator' the weather conditions deteriorated and the wind picked up to Force 5. Eventually the group were making such little headway in the choppy conditions that the decision was taken to tow the raft with the safety boat. The towing arrangement allowed the rafted canoes to lurch back and forth and to swamp, pitching the 8 team members into the water.

The instructor remained confident that he could recover the situation. He contacted the centre by mobile phone, and they dispatched two other ribs to the scene, but they were then 7 miles away.

The attempt to recover the rafted canoes and to get the team back on-board resulted in a further capsizing. Attempts to get everyone aboard the 4-man rescue boat resulted in it swamping and capsizing as the boats drifted ever closer to the shipping channel. The developing incident was spotted by a passing supply ship which came directly to the rescue.

The entire episode was investigated by the Marine Accident Investigation Branch (MAIB) as a near-miss and a report subsequently appeared in their Spring 2006 Safety Digest.

The lessons

1. Single canoes can roll with the wave action; rafted canoes can not, rendering them more likely to swamping, rather than less. Once swamped the craft is unlikely to be functional and is prone to capsizing. Had the organisers realised this, prepared for it, practised their proposed towing arrangement, etc. it is unlikely the incident would have occurred;
2. The 'facilitator' was from a management training organisation, and the safety boat instructor was from the activity centre which provided the canoes. It appears it was not clear who was actually 'in charge' of the session, the instructor or the facilitator;
3. The repeated decision to continue with the exercise came about largely because of two factors:
 - a. The perceived pressure to continue with the exercise;
 - b. Nothing in the written brief allowed for a modification of the exercise as a result of, for example, adverse weather or sea conditions. The only options were to continue as per the brief, or cancel the exercise altogether;
4. The exercise was designed to simulate certain aspects of business situations or practices. However, it failed to acknowledge that, as in business, external factors can dictate a complete and rapid change of plan, such as computer failure or crucially missing personnel, equipment, information, etc. It should have been possible to build a Plan B into the written brief, which could be activated by the delegates, radically alter the exercise and still provide sufficient 'material' for the 'facilitator' to review afterwards. That is, "did delegates respond quickly and efficiently with the transition to Plan B? "Did delegates cope with Plan B even though they were expecting something completely different?" etc;

5. The rescue boat was too small for 10 people. This however could just be a consequence of not realising that an "all-in" situation was a possibility. With this now as a given, the rescue craft would need to be either large enough to carry all participants, or be able to ferry participants to the shore. In the latter case thought would need to be given to participants' clothing;
6. MAIB were highly critical that the emergency services were not contacted. Indeed the rescue boat had neither flares nor a marine radio. In essence the MAIB were critical of the decision of the instructor to continue to attempt to self-rescue when external rescue had clearly become the sensible option.