Epics, Lies and Hero Stories: The folklore of near misses in the outdoors

By Cathye Haddock

Thank you for the warm introduction and for inviting me to address this conference. I feel very privileged to be here.

Ko Tongariro te Maunga

Ko Taupo te Moana … ka rere tonu, ka rere tonu, ka rere tonu
Ko Tuwharetoa me te Irihi taku Iwi
Ko Haddock taku Hapu

Nga tini aitua kua haere ki te po haere atu ra.

Tongariro is the sacred mountain where I grew up.

Taupo is the lake … it's flowing, flowing, flowing.

Tuwharetoa and the Irish are my people.
Haddock is my sub tribe.

I acknowledge the many that have fallen, farewell.

Te whare etu nei, te whare hohonu, te whare wananga tena koe.

This house that I stand in, a house of learning, a house that embraces us, I greet you.

Nga uru rangatira, nga kaiwhakahaere o tenei hui, kei te mihi aroha kia koutou.

To distinguished guests, managers, leaders and instructors, I give you warm greetings.

No reira, Tena koutou, tena koutou, tena koutou katoa.
I greet you all.

I speak to you this morning as an educator, as a student, as an adventurer, as a woman and as a Kiwi from Aotearoa / New Zealand. Please settle into your seat and have a listen. I would like you to …

Imagine an alpine valley. It's winter, it's cold, snow is scattered about the tussocks and rocks. Only shrubs, no trees at this altitude. A crisp breeze is blowing. A school group has gone on a day walk up the alpine valley to a hut for lunch and is on its way back in two groups, twenty minutes apart. The following are an instructor's words, describing the return trip:

> *An enormous avalanche had ripped out a kilometre around the headwall, it just came bursting out of [the] gully…when I heard the boom ahead of me, I yelled at the kids behind me to go back and get shelter behind a rock, there was bugger all there they could hide behind…It burst through the rocky bluff that is down hill from the basins above … absolutely enormous freight train of an avalanche, it scares me even now to think about it, and it was rolling, so it slopped up both side walls of the gully as it came…in a tongue…and it looked as though it was going to come down onto us…I just quietly had a look around…I didn't know what I was looking for, I was looking for bodies hanging out the other side of it…I was looking for anything human down in the lake…* (Michaela).

This is a near miss in the outdoors. An epic tale told and retold by the children and teachers that experienced it. One that had no tragic consequences – but so easily could have.

These types of events fascinate me. I have lain awake at night tossing and turning over epics I've experienced myself with groups of students, and felt enormous social and professional pressures not to disclose too much, especially of my own mis-judgement, for fear of being judged incompetent by my peers. I have observed over the years though, how these events are often re-told, in the form of an epic adventure where the teller gains hero status, yet many listeners realised this was a serious near miss which they 'got away with'.
My fascination led me from the polypro and polar fleeced life of an outdoor educator, to the pen, paper and personal computer oriented existence of a student in pursuit of a masters degree. Adventure education out in the elements was replaced by adventures in thinking as I engaged in the joys of postgraduate study. And so it was that I decided to research near misses in the outdoors.

My address this morning relates to some findings of my research into epics and is in two parts. In part one I outline my research aims, describe the research setting and sample and review key points in the literature relating to incidents with high potential for harm, to give context to the research. In part two, I build a definition of an epic based on teachers' and instructors' responses and explore meanings of the events in the social context of outdoor education. Finally I pose a challenge for everyone. I do hope this address will mark the beginning of many conversations that will take place around the few points I want to make this morning. We learn well by engaging in a topic.

As a specialist outdoor educator working in a school-based programme where occasional 'near miss' incidents were a part of my outdoor lifestyle and work, I wished to learn more about these memorable and often turgid experiences. My interest was two-fold:

- To explore meaning/s for those involved, thereby discovering what place these events occupied in the outdoors culture. Why they were integrated into the folklore as epic adventures when often those involved were traumatised or shaken by the experience.

- To examine the anatomy of a near miss, deconstructing it to see if analysis could determine causes and preventive action.

My research was carried out at the Rotoiti Lodge Outdoor Education Centre which is located in Nelson Lakes National Park in the South Island of New Zealand. The Centre caters for 13 secondary schools in the region. I used qualitative methods to elicit information about high potential incidents which occurred in the programme. I held ten interviews, five focus groups and used pre-existing incident records to gather data. My respondents were people who ran or assisted on the camps, outdoor educators or instructors and curriculum teachers.

Safety is a perplexing issue in outdoor education as safety versus risk is a paradox. While risk is a fundamental ingredient of adventure experiences, safety during the experience is expected (James, 1980). This is especially true within an institutional framework, such as a school, or the adventure education profession. Schulze (1980) identified an ethical split between public and private safety: *'knowingly imposing a risk on oneself is 'right' whereas imposing a risk on someone else is 'wrong''* (p. 218).

In other words, I can quite happily go off and climb Mt Hood next week after the conference, be killed in an avalanche, gain a two inch article on page 34 in the newspaper and society will accept that. I freely chose to climb Mt Hood, knowing and accepting the risks, so that's sad but fine. However, if I booked onto a canyoning excursion in Switzerland and was killed along with 21 others on the trip, that would not be okay. It would get world wide front page and TV news coverage and the event would be amplified throughout the wider adventure industry. An inquiry would be called for as society would not tolerate or accept such an event. These people paid for the feeling but not the essence of risk, they did not pay to be killed.

Literature reviewed

To give us a common basis for understanding these events, I want to skip through some key points from industrial and outdoor research that I believe provide important background to the topic of near misses or incidents with high potential for harm. I acknowledge that an audience of wilderness risk managers may be familiar with much of this material. Industrial research in particular has made a huge contribution to the understanding of accidents and incidents. Some outdoor authors have seen the usefulness of this research for outdoor safety (Davidson, '92; Kauffman, '89; Meyer, '79).

The Accident Ratio Study[1] (Bird and Germain, 1992) suggested that accidents resulting in serious injury were just the tip of an iceberg. This analysis of industrial events found that for each serious injury or fatality there were ten minor injuries, thirty cases of property damage and six hundred incidents with no visible injury or damage (a 1:10:30:600 ratio).

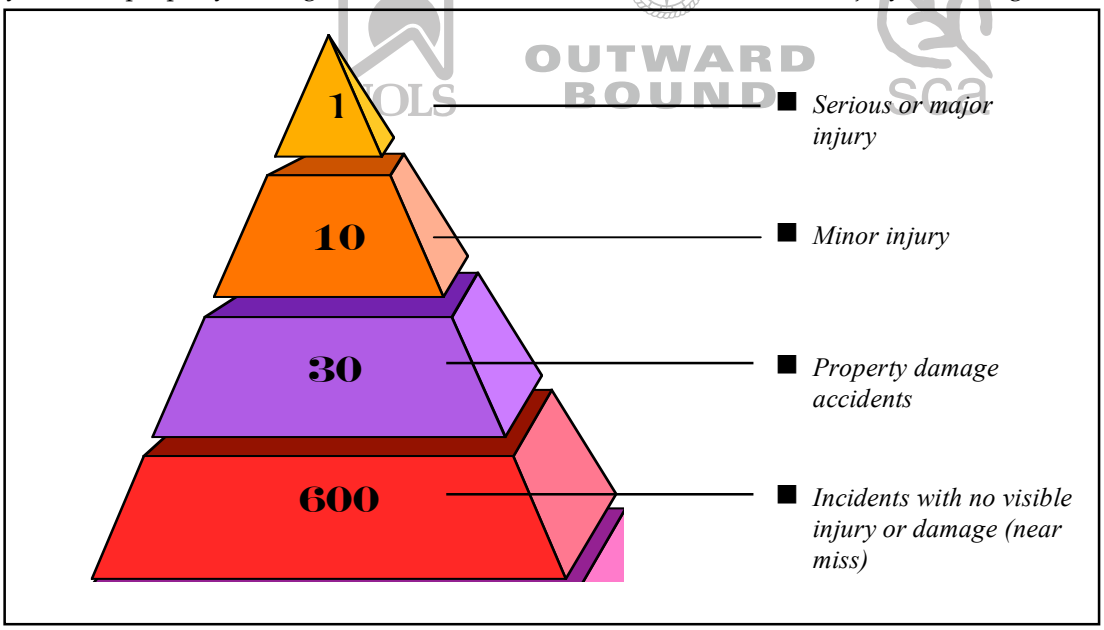

Figure 1 Accident ratio study (Bird and Germain, 1992, p. 21).

[1] This study analysed nearly two million events reported by 300 companies involving two million employees who worked three billion person hours (Bird and Germain, 1992).

But authors debated whether minor accidents (or incidents) predicted major accidents? (Bird and Germain, 1992; Johnson, 1980; O'Shell and Bird, 1969). Johnson (1980) argued that the principle was misapplied if all incidents were lumped together. He reported that as early as 1940, a National Safety Council (USA) study in the electric utility industry pointed out that minor injuries (bumps, bruises, minor cuts and dust in the eyes) did not focus on causes of electric shock fatalities. Likewise, studying blisters in the outdoor recreation setting probably won't help us prevent river drownings.

Within the minor to major event continuum, a specific type of incident had significance. 'Near miss' incidents with high potential for serious harm (HIPO incidents) could predict more serious accidents in ways that typical first aid cases could not. So, they should be investigated as thoroughly as accidents (Bird and Germain, 1992).

Hale (1989) advocated that outdoor programme leaders should also take note of these events. He described four indices of close calls, those involved: express relief, often through exaggeration and humour; often do not identify it as a true accident and do not report it formally; therefore no analysis is made; no analysis means no intervention to stop or alter the close-call circumstance, tending to promote a recurrence, often with escalating seriousness. Hale suggested information from a close-call should be documented, analysed and networked among peers in that and other programmes. I believe there are social and professional barriers to this happening, some of which I'll raise and discuss in Part Two.

HIPO incidents have been shown to be related to accidents in that they have similar causes (Bird and Germain, 1992; Hale, 1989; Johnson, 1980; Kates, Hohenemser and Kasperson, 1985; Kauffman, 1989). Yet incidents went grossly under reported (Dwyer, 1991; Hale, 1989; O'Shell and Bird, 1969) and were even *'shrouded by a veil of silence'* (Dwyer, 1991, p.6). HIPO incidents differed from accidents in that no injury or damage resulted. But the type and degree of loss were a matter of chance, depending partly on luck and partly on the actions taken to minimise the loss (Bird and Germain, 1992).

An example of this is in the avalanche story. When the group arrived at the hut, they huddled inside to have their lunch. An instructor went outside at one point and was amazed by what she saw. There was a brief clearance in the cloud and mist shrouding the valley and tops. To her horror, she saw not only that it had been snowing up high as they walked up the valley but how much snow there was, packing the basins above. Immediately she spoke to the teacher, got him and his group of kids to pack up and get going down the valley whilst she stayed behind with the second group to finish lunch, tidy up the hut and left 20 minutes later. On one hand it was pure luck that the avalanche came down between the two groups, leaving them both unharmed. On the other hand, the instructor's decision to split the group with one group leaving immediately, saved their lives. This brings resonance to Mitchell's words: '*The difference between a near hit and a fatality is often only a few millimetres or a fraction of a second'* (1998, p. 40). Consequently, the effect could range from insignificant to catastrophic, from a scratch or dent to multiple fatalities or loss of plant (equipment or buildings) (Bird and Germain, 1992).

Determining significant events

Delineating high potential 'near-miss' incidents from minor accidents and incidents with no relationship to major accidents, poses a challenge. Johnson (1980) highlighted the importance of *'the professional scan of minor injury reports and property damage reports ... to bring to light cases of potentially great significance.'* (p. 371). This relied on the input of someone with expertise in safety and the particular industry. A combination which, I imagine, many of you possess. Several tools have been developed to assist the professional in this endeavour. Albrighton's (1993) risk assessment model is one such tool which I used in my research*.

Accident and incident analysis

Several authors saw the importance of identifying contributing factors to accidents (Raffan, 1984; Kauffman, 1989). They highlighted the significance of the HIPO incident in affording an opportunity to analyse contributing causes to an incident without a death or serious injury necessitating the process. Although the trend in accident analysis was to reduce and simplify events into a linear sequence, researchers (Bird and Germain, 1992; Johnson, 1980; Kates *et al*, 1985) acknowledged that accidents were complex events and more tree or web like than linear*.

* For full details, see 'High Potential Incidents – Determining Their Significance' by this author in these proceedings.

Contributing causes

The literature highlighted common and significant causes of accidents and incidents in the outdoors*. These closely matched contributing factors to the eleven HIPO incidents in my study*. Other factors were derived from the data*. All are illustrated in Figure 2 below. Notably, eight of the fifteen factors displayed on Table 2 also contributed to the avalanche incident (which was part of a previous study).

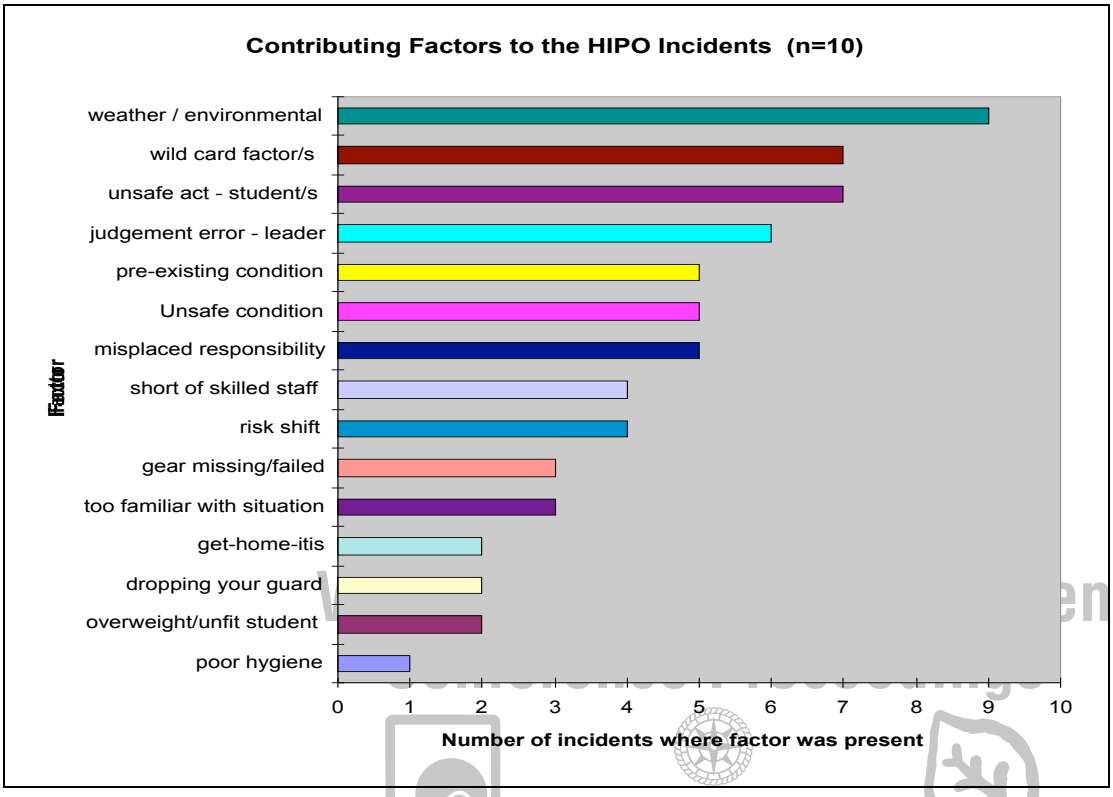

Figure 2 Contributing factors to HIPO incidents by themes

You may be wondering what 'wild card' factors are, near the top of the graph. I identified these factors as contributing to HIPO incidents in an earlier (1996) study. These factors were characterised by their unpredictable nature and usually resided in the colleagues or students a leader was working with. For example, behaviour which took leaders by surprise and put them in a reactive mode, often without all the information.

A classic example of a wild card factor was in the avalanche story. The day before the incident, Michaela asked the teacher to go to the Park Headquarters and ask the rangers for information on the track condition and avalanche risk. He was told that the avalanche danger was too high and advised not to go. He came back and said 'everything's fine', so the group set off early the next morning. You know the rest of the story. Now as it transpired, Michaela found out some weeks later that the teacher had some rivalry going with a teacher back at school who did this trip on alternate years. There was kudos to be gained from the one who got their group up the valley to the hut and back. So his motivation was to achieve this come hell or high water. This guy was a wild card!

Authors agreed that efforts must be made to recognise and analyse HIPO incidents (Ewert, 1984; Hale, 1989). My research showed that leaders certainly recognised a HIPO incident when they had one. But HIPOs were not always analysed and acted upon afterwards. For example, the avalanche incident was not debriefed or analysed by the school according to Michaela, who was contracted for the week of the camp only. She said:

> *There was an awful lot of relief and I think people at school were just feeling 'thank god no one was hurt' and they hadn't quite got to the stage of dealing with why the hell it had happened.*

You can just imagine the investigation that would have occurred if people had been killed. A lost opportunity, yet this does happen. For example, Helms (1984) found that the majority of mountaineering accidents in two studies were preceded within one year by a near miss or accident of a parallel nature in the same area. Kauffman (1984) found crucial factors in a mountaineering accident involving multiple fatalities on Mt Hood, had been present in the programme in previous years. Both agreed the leaders failed to recognise these factors as important (also supported by Brett, 1994).

Although HIPO incidents are hailed as critical to safety, studies of these events are almost completely invisible in the literature, which is dominated by quantitative studies of accidents and illness in the outdoors. This leaves word of mouth as the main way near misses are communicated in the profession and the associated inaccuracies that spread around. In a culture quick to judge our peers, outdoor leaders are in a vulnerable position after a mishap. With a serious accident where losses have occurred, the event becomes highly visible and open to scrutiny. There is little choice. Whereas a near miss incident with no visible losses, allows the option of less visibility and less scrutiny. In a culture quick to revere heroic deeds, there is always the loophole of a bit of story-teller's licence. I for one have found ways to exploit this option. As my study progressed, I found I was not alone.

PART TWO

EPICS - Towards a definition

And so to epics… I had heard and used the term epic for over 20 years of adventuring and working in the outdoors. I had told and heard many a good outdoor story through this medium. But do you think I could find any reference to it in the outdoor literature? There were well-developed theories and concepts for an accident and incident but none existed for an epic. Finally, I opened the dictionary.

1 *a long poem **narrating the adventures** or deeds of one or more **heroic** or legendary figures*
2 *an imaginative work of any form, embodying a nation's conception of its **past history***
3 *a book or film based on an **epic narrative** or **heroic** in type or scale*
4 *a subject fit for **recital** in an epic*

This definition implies that an epic was the *story* of heroic figures and their adventures, rather than the events themselves.

In the absence any mention of an epic in the outdoor literature consulted, my respondents' ideas form the basis of a definition and further understanding of a previously little researched concept. Their voices are with me this morning. Notably, only 16 of my 29 respondents in the study, knew what an epic was in an outdoor context. They were experienced outdoors people who recreated and/or worked in the outdoors regularly. The others were teachers who had limited outdoor experience apart from their involvement in school camps, indicating the term was exclusive to the outdoors culture. It was not exclusive to New Zealand however. Respondents from England, South Africa, Australia and America said epic was used and understood among outdoor people in their countries.

Three different types of epic were described by instructors and are illustrated on the epic spectrum below. Categories are arrayed from least risky on the left of the spectrum to most risky on the right, to display the relative seriousness of events. All began from the premise of a long hard trip. On one strand, the epic would remain a long hard trip. On another strand it could become an epic adventure involving long duration with the fun and exhilaration of achieving a goal. On yet another strand, an epic could be a long hard trip which involved a close call in a high risk situation. This was a negative experience with folk *'realising how lucky the people have been to get away with it'* (Norm). This manifestation of an epic is the one I was interested in for my study. It sounded akin to Mortlock's (1983) description of misadventure:

> *Like adventure, misadventure is a state of mind. Unlike adventure, the immediate reactions are essentially negative rather than positive. At one extreme the result is death or serious injury. At the other extreme are feelings of relief that one has escaped any serious consequences from a situation that was unduly stressful and more demanding than one had conceived at the onset of their journey. The enjoyment, satisfaction and euphoria that can arise from adventurous experiences are replaced by negative feelings of 'Thank goodness that's over', or, 'God that was lucky'.* (p.41).

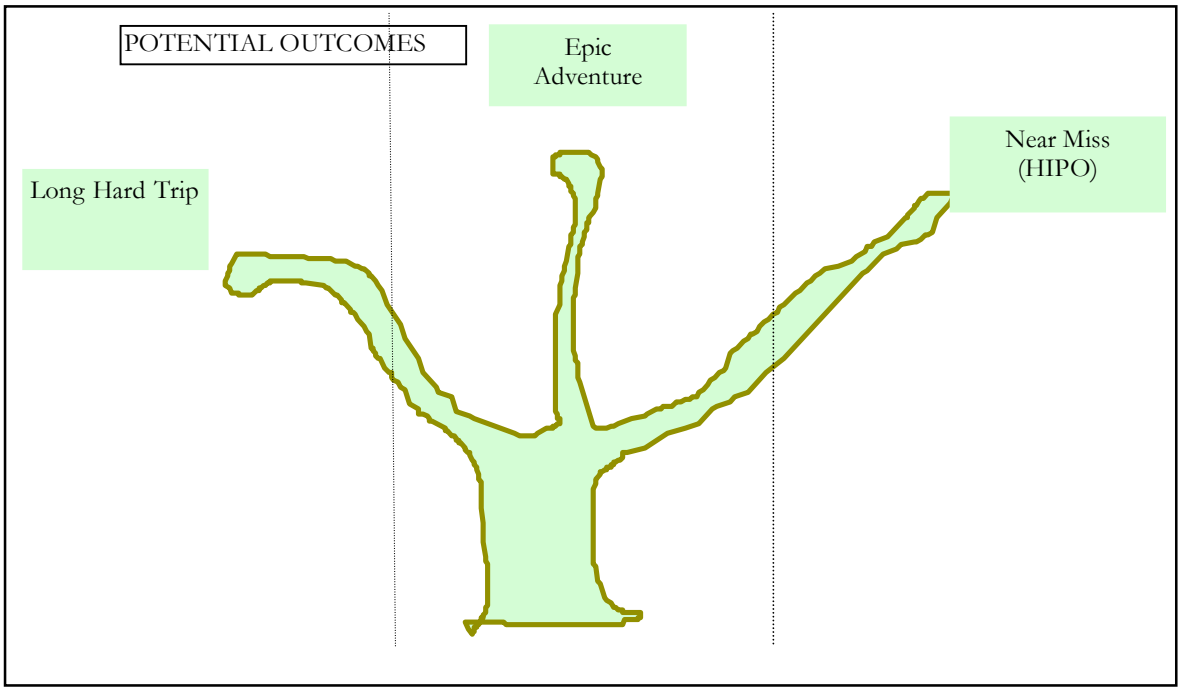

Figure 3 The epic spectrum [revised].

Respondents described 18 different elements of an epic. Some elements were intertwined but all contributed to the meaning/s of an epic to them. The elements are displayed in Figure 4 below. Together they provide a framework for defining an epic.

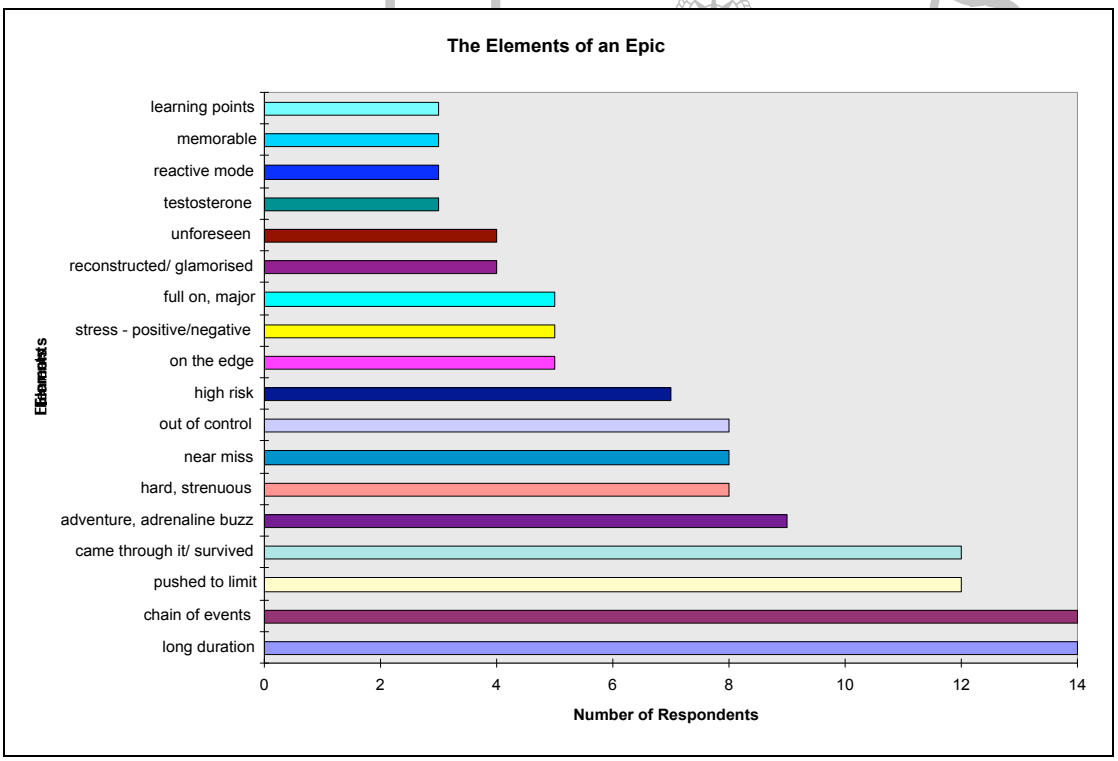

Figure 4 The elements of an epic

The language used by outdoor educators and instructors to describe what an epic was like, struck a few chords with me. So I got out Martin and Priest's (1986) adventure experience model which has been adapted several times both in New Zealand and North America. In particular I was looking for where *pushing the limits, on the edge/ line* and *out of control* fitted on the model. Many used these expressions to describe epics. I have displayed where I think they fit on the model in Figure 5 below.

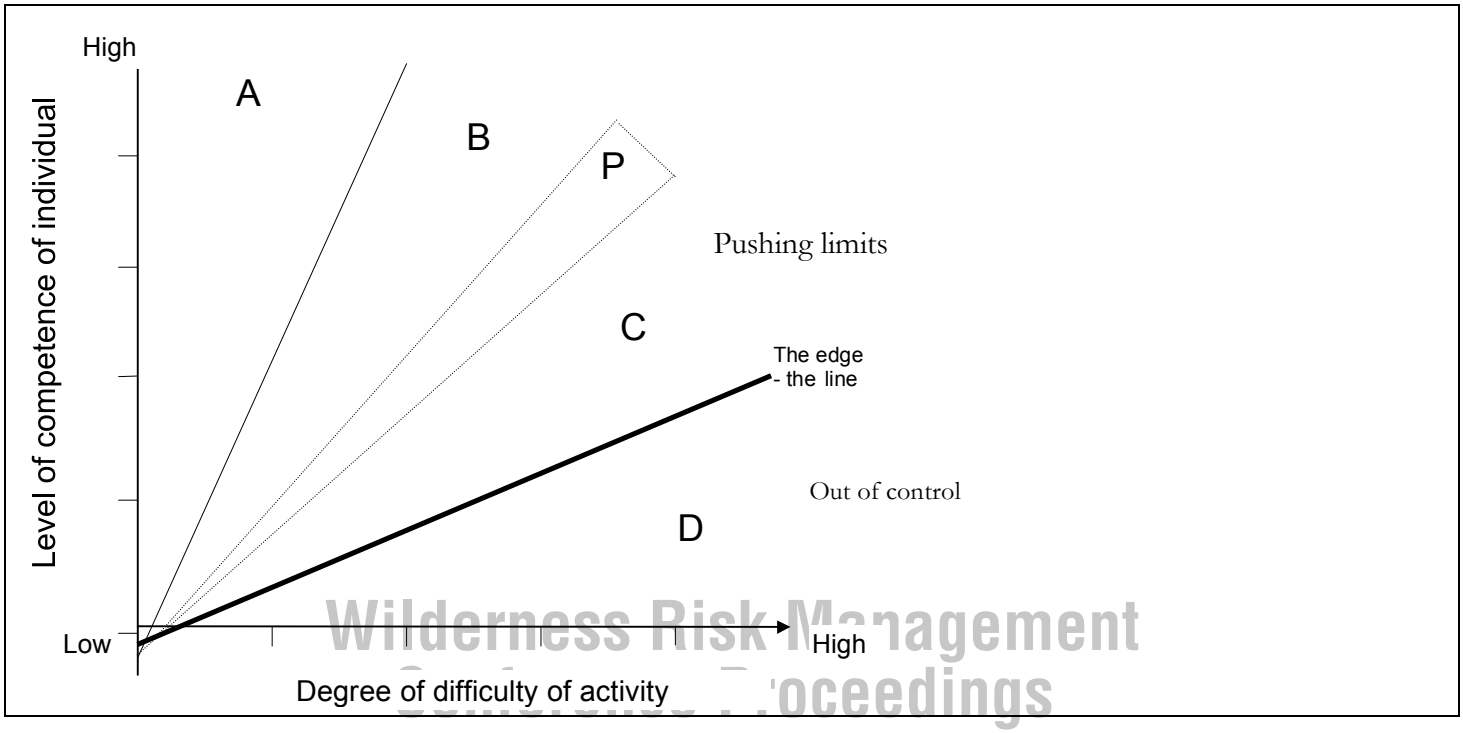

Figure 5 Operation Zones Model (adapted from Martin and Priest, 1986).

The following descriptions explain the operation zones illustrated in Figure 5 above:

A Boredom zone was where competence was far above the difficulty of the task. There was no stress and it could be boring.

B Cruising zone was where competence was comfortably above the difficulty of the task. There was low stress as you were within your comfort zone.

P **Peak Experience** zone was where competence matched the difficulty of the task. This well researched state of being was described as 'flow' by Csikszentmihalyi (1975). There was positive stress, and a sense of adventure.

C Challenge zone was where competence was slightly less than the difficulty of the task. There was positive stress as you **pushed your limits** and learnt more.

The edge - The 'fine line' between **C** and **D** zones, depicted the edge or fine line between *pushing your limits* and being *out of control.* There was high negative stress bordering on panic.

D **D**istress or **D**anger zone was where competence was far below the difficulty of the task. There was extreme negative stress, a feeling of being **out of control** and a serious accident or near miss was highly likely in this zone.

According to my teacher and instructor respondents, HIPO incidents could be: mis-reported, euphemised or exaggerated. In other words, reconstructed into epic adventures, white lies and hero stories. Or, they could be brushed off as insignificant.

Phoebe's story came into the category of *misreported*. She told me the story of her first leadership experience leading a group of 14 students on a two day hike. Significant in her story were her painful, pre-existing leg injury which got worse as the trip progressed, her nervousness about her first experience of leading a group on her own; the heavy rain, thunder and blue lightning and a boy who vomited all over his sleeping bag in the hut as a result of eating too many sweets. Phoebe described herself as being pushed to the limits. However the official record only mentioned the sick boy and recommended that disinfectant be made available in the hut to clean up such messes. I don't think Phoebe deliberately mis-reported this event. I believe her inexperience as a leader probably affected her awareness of issues which compounded the incident.

Some epics were seen by my respondents as *reconstructions* of events to show them in a different, more positive light. Attribution bias (Baron and Byrne, 1994) could account for this. Psychology researchers have found that sports teams do this all the time to account for their wins and losses. Their natural tendency is to attribute negative outcomes such as losing, to external factors like the weather, the ref' or a 'freak' occurrence. Conversely they tend to attribute positive outcomes such as winning, to internal factors like their teamwork and heroic efforts. Outdoor people can be affected by attribution bias too, with some epic adventures actually being HIPO incidents in disguise. Charlie said:

> *'The New Zealand framework here is that … it's a polite way of avoiding saying that we stuffed up … covering yourself and calling it an epic instead. Most people who have spent a bit of time in the outdoors have had epics, I don't know of anyone, if they were honest about it, who hasn't … there has been some lack of judgement … if you look back and analyse it all …'*

Continuing the discussion in this focus group, Baz said:

> *I think one of my epics would come under that category quite well … my epic title is probably covering up for the fact that …our weather forecast research wasn't brilliant … I didn't have my crampon adjusted as well as I could have … so those weaknesses in my planning probably led to what I'm now calling an epic.'*

Reconstructions can be found when reading about people's epics also, which I love to do. In Hunt's biography of Vilhjalmur Stefansson, a Canadian arctic explorer, Stef had an interesting perspective on adventure. He reckoned that '*adventure was a sign of incompetence'*. Whenever someone came back telling a story of adventure, he was thinking that they stuffed up.

Agatha saw epics as an opportunity for *exaggeration*. She said:

> *But at the end …it's sort of like the long fish, you know, catching the big fish? And it gets very distorted by drama and all sorts of other things … and later on …it has a glamourous side to it … it suddenly gets bigger and better and more close to the edge …'*

In wondering why folk re-tell a HIPO as an adventure or exaggerate some aspects of it, a number of respondents said it was to attain kudos. Garth epitomised this view when he said: *'Later on it gets a bit of hero status'*. The literature agreed. Freedman, Carlsmith and Sears (1970) *cited in* Allen (1980) studied risk takers such as parachuters, investigating why they engaged in their sport. They found:

> *Taking risks indicates courage and forcefulness, and is generally more highly valued than conservatism. Most people, particularly men, tend to respect and admire others who are willing to take risks. Being in a group reinforces the importance of the social desirability.*

Interestingly, being in a group impels people to increase the level of risk they are prepared to take also. This is the well documented risk shift phenomenon where groups take riskier decisions than individuals. The above researchers claimed that men are more susceptible to risk shift. To illustrate, just imagine three sea kayakers paddling around a headland. As they approach it, the current is getting stronger and the wind is picking up. A reflective chop is coming back off the cliffs and colliding with the incoming swell. The sea's getting messy now as the wind is whipping the tops off the confused criss crossed chop. The paddlers are each feeling increasingly uncomfortable in the conditions, yet they are equally determined not to be the first one to speak up and say 'Hey, I'm not feeling too happy here, let's turn around and go back'. So, they paddle on, getting closer and closer to the edge of their abilities.

My respondents also picked up on the testosterone factor:

- *There's a definite link between testosterone and epics* (Garth)
- *There's a certain amount of testosterone floating around in it* (Agatha)
- *It's more particularly amongst males … in our culture … it's more a case of maintaining an image of a tough kiwi bloke or blokess* (Charlie)

I hasten to add that testosterone is not a hormone that's restricted to males. I have a good deal of it myself at times!

The following definition is a synthesis of the ideas discussed above which respondents came up with.

EPIC

A long hard strenuous outdoor trip involving a chain of events that puts people into a reactive mode, pushing their limits until they feel out of control. It is a major, unforeseen event involving perceptions of risk and misadventure which create stress. Memorable learning experiences that people survive, they are often glamorised afterwards, creating the 'epic'.

Meanings

I was curious about how meaningful HIPO incidents were to those that experienced them. Meanings had a number of themes. Norm said:

*I'd say most of the time it's just brushed off … [I doubt] whether they see the frequency and all that sort of thing … basically they probably don't. They probably see it as a **one off** thing rather than something that might be recurring, maybe leading to an accident in the future …*

Ben felt that some made efforts to hide HIPO's. He said:

Maybe y'just were afraid to admit it and glossed over it … human nature being what it is … [maybe] they're insecure.

Far from brushing these experiences off, as it may appear from conversation or outward behaviour, HIPOs were deep learning experiences for most as shown by the following comments: *it was a serious practice exercise; a test we passed; it sharpened my judgement; you learn your bounds and limitations; learned my own needs and comfort levels; learn from your mistakes.* Whereas some saw a HIPO incident as a 'one off' with no further action required, most saw it as a warning to alter something in their own behaviour or in the programme. The following comments were typical. The incident was a: *tap on the shoulder; wake up call; warning bell; reminder.*

Further meanings of HIPO incidents included: *part of going into the outdoors; some are unimportant; affirmations of safety practices and systems in place; strengthening of the group and / or themselves; bottom of scale of things that can go wrong, bottom of pyramid.*
So where do HIPO incidents fit in the event continuum? The HIPO fits in between serious accident and minor accident/incident. I have turned the pyramid on its side to reinforce the continuum concept.

The pyramid shape shows the frequency of occurrence, with most frequently occurring events at the base of the pyramid and least frequent at the apex. Dotted lines depict that boundaries between the types of events are by no means solid. The linking arrows indicate that certain less serious events can lead to a more serious event. The relative degree of severity of events is represented by the continuous arrow beneath the pyramid and the decreasing area toward the apex of the pyramid, showing the least frequent events as most severe.

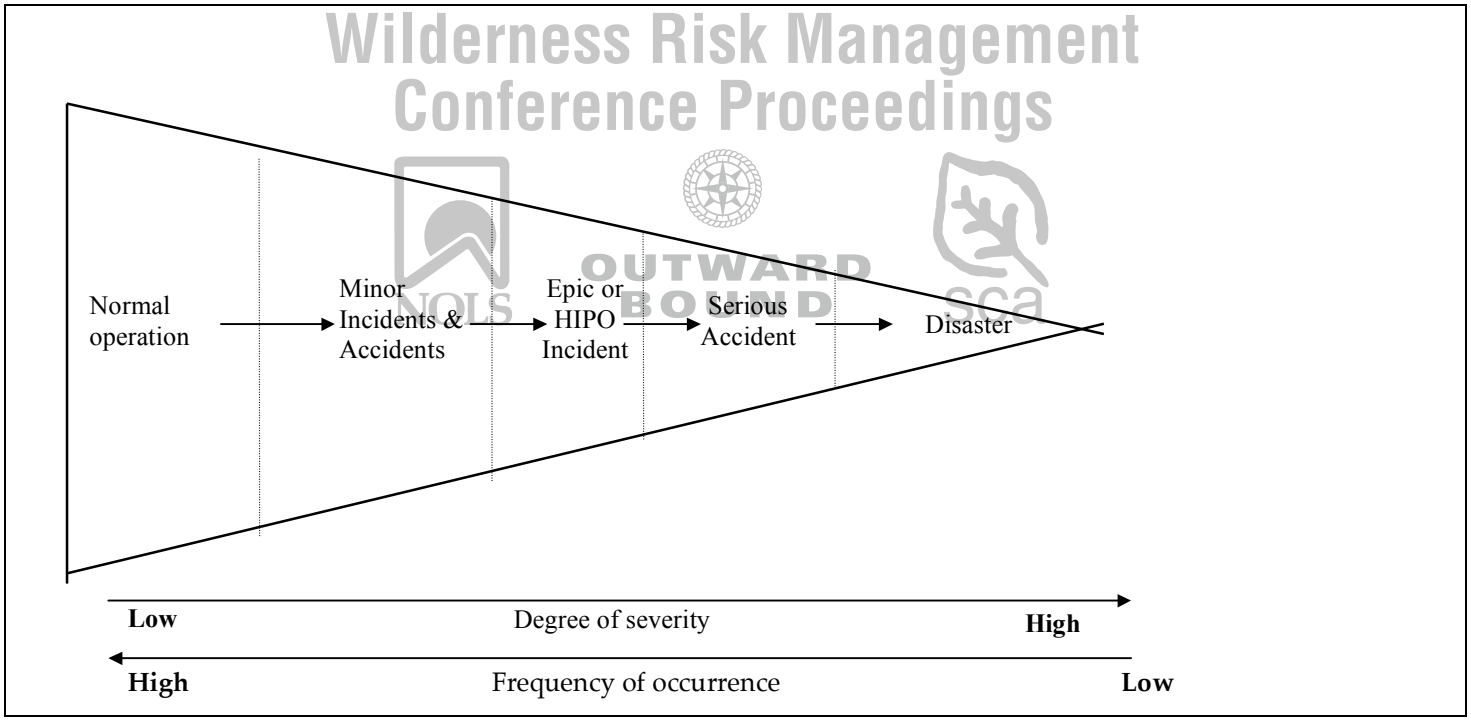

Figure 6 Pyramid of events

And so one manifestation of the epic can finally be seen for what it is. The reconstruction of a serious incident or near miss, making the event visible whilst maintaining face in a culture quick to judge in hindsight, whilst quick to revere heroic deeds. Is it any wonder then, that many of us choose to re-tell our memorable HIPO experiences as epic adventures, embellishing a bit here and a bit there to avoid the harsh judgement of our peers? After all, we got away with that one, due to our heroic efforts. And so the visibility is blurred.

I examined how information about these events was passed on. A common method in schools was by word of mouth, beginning with a joke. Eric said:

… it's not until some time down the road, maybe at a function … that it's let slip that … 'such and such happened' and everyone has a good chuckle about it. But at the same time you can see … half a dozen light bulbs going on around that conversation as people … think 'hell … that could've happened to me'.

Or hell, that did happen to me!

I wonder how much has changed since 1989 when Hale encouraged us to recognise close calls, report, analyse and network them among our peers? Have they been reported more often over the last decade, so that measures can be put in place to reduce the chances of a recurrence? Why are they still largely invisible in the literature? Are the social and professional pressures influencing us? What sort of environment needs to exist for us to report HIPO incidents? My instructor and teacher respondents felt the following components were required for them to feel comfortable reporting incidents: A 'no blame' forum where there was a goal of learning and prevention. An informal atmosphere was best with a formal process which involves everyone and requires a minimum of paperwork. There also needed to be definite follow up with suitable analysis & appropriate action taken.

It's no easy feat to set up these types of procedures. Over my 6 years as a programme manager at Rotoiti Lodge Outdoor Education Centre, it proved to be a long slow process to gain the trust and confidence of staff to discuss incidents which occurred during the programme. We had a permanent staff of two with over a hundred teachers and instructors per year accompanying their groups of students on the programme. When I first arrived at the Centre, no debriefs were held at all. The first debrief we held was after a serious incident, and the main teacher involved refused to come. Another person sat on the edge of his seat for the whole meeting with his kayak helmet on giving us the message that precious kayaking time was ticking by. Tensions were extremely high throughout the process. But we learned heaps. Over time processes developed and improved – thank goodness. Bruce who has been involved since the beginning, describes the kind of settings which help the process and which do not:

…it depends on the context ... when I'm just informally talking with people, that's fine, but if somebody were to corner me and try to be blaming me for something (laughs) then I would feel very uncomfortable ... and that's why I think it's really important to set up systems where people can do it. I think familiarity with the whole debriefing process makes a big difference, because I've noticed a change in even my feelings about it ... that's taken time of being involved with the process and seeing the value of it ... When I'm in a group of people where it's the norm, then it's very easy, but when you've got a number who are not happy with it themselves, then ... it becomes difficult again.

In April of this year I took on the role of safety officer for the Kiwi Association of Sea Kayakers (KASK). I have undertaken to set up reporting procedures for incidents in the recreational setting of sea kayaking nation wide. My aim is to develop a database and analyse individual events and annual data to gain a depth and breadth of analysis from which we can all learn. Every network meeting I go to, I sit and listen to people's stories of epics they've had. I have a good laugh along with everyone else. But again, getting people to write a report on these is a different affair. Some incident reports are sent in voluntarily from the regional networks, but these are few and far between. Several people have been proactive in obtaining accounts of incidents through phone interviews and asking people to write the events up. We also have a few taped interviews and debriefs of horrendous incidents that network members have experienced. I want to help create a culture where it's okay and normal to talk honestly about these incidents and to pass on the lessons learned from them without the emotionally charged situation of a serious injury or death to tip toe around. To encourage more incident reporting, we have introduced a 'Bugger File' in our national newsletter. You probably have to be a kiwi or an Aussie to appreciate this. We are trying to lighten up the reporting of HIPO incidents by using a bit of humour to encourage people to write in about their 'oops'. Our aim is to get people used to talking and reading about incidents in the newsletter. To facilitate this, we offer confidentiality of names and places if people feel too exposed and the option of the incident staying in the file and not being published apart from as numerical data. This gives people power over what happens to the information.

Conferences provide us with plenty of stimulation to discuss and debate all sorts of issues with our friends, colleagues and peers. Our culture of the outdoors is rich with the folklore of near misses, often in the form of epics, lies and hero stories. I pose a challenge to our profession, to change the culture surrounding serious incidents in the outdoors. Let us discuss these events openly and freely, with honesty, and without fear of judgement. Let us also listen attentively to our colleagues, our friends, our competitors, without judgement. They'll still make great stories and with further analysis and networking, we can take the opportunity to learn the lessons they learnt so harshly, because as Jane said:

…that's the nicest way …when you hear somebody else's … you can appreciate all of this and take that learning on. But you didn't have to do it yourself!

Thank you.

Cathye Haddock is a senior lecturer in recreation at the Central Institute of Technology in Wellington, New Zealand.
Email: haddock.simpson@xtra.co.nz

Thanks to Marg Cosgriff for her editorial comments.

REFERENCES

Albrighton, L. (1993). Emergency response - planning for crisis management. Safeguard: Journal of Occupational Safety and Health. July, 17-19.

Allen, S.D. (1980). Risk recreation: a literature review and conceptual model. In Meier, J.F., Morash, W.T., Welton, G.E. (Eds.), High adventure outdoor pursuits: organisation and leadership. (pp. 52-81). Brighton Publishing, Utah.

Baron, R.A., & Byrne, D. (1994). Social psychology: understanding human interaction (7th ed.). Allyn and Bacon, Boston.

Bird, F.E. Jr., & Germain, G.R. (1992). Practical loss control leadership. The conservation of people, property, process and profits. Institute Publishing, Loganville, Georgia.

Brett, C. (1994, February). Death by adventure. North and South. Pp. 41-45.

Csikszentmihalyi, M. (1975). Beyond boredom and anxiety. Jossey-Bass, San Francisco.

Davidson, G. (1992). A safety auditing instrument for adventure education. Unpublished master's thesis, University of Minnesota, Duluth, USA.

Dwyer, T. (1991). Life and death at work. Industrial accidents as a case of socially produced error. Plenum Press, New York.

Ewert, A.W. (1984). The risk management plan: promises and pitfalls. Journal of Experiential Education, 7(3), 27-32.

Haddock, C.M. (1996). Teachers talking about their epics. Part II. Matauranga O Aoturoa, A Journal for Outdoor Educators and Instructors. April, pp. 3-7.

Hale, A. (1989). Close calls, ignore them at your peril. Journal of Adventure Education and Outdoor Leadership, 6(1) 11-13.

Health and Safety in Employment Act of 1992. Pub. L. No. 96. Wellington, New Zealand (1993).

Helms, M. (1984). Factors affecting evaluations of risks and hazards in mountaineering. Journal of Experiential Education, 7(3), 22-24.

Hunt, W.R. (1986). Stef - a biography of Vilhjalmur Stefansson, Canadian Arctic explorer. University of British Columbia Press, Vancouver, Canada.

James, T. (1980). The paradox of safety and risk. The journal of experiential education,3(2), 20-33.

Johnson, W.G. 1980. MORT safety assurance systems. National Safety Council, Chicago, USA.

Kates, R.W., Hohenemser, C., & Kaspersen, J.X. (1985). Perilous progress: Managing the hazards of technology. Westview Press, Boulder.

Kauffman, R.B. (1989). Recognising the accident chain. Parks and Recreation, 24 Sept, 68-73.

Martin, P., & Priest, S. (1986). Understanding the adventure experience. Journal of the National Association of Outdoor Education, 3(1), 18-21.

Meyer, D. (1979). The management of risk. The Journal of Experiential Education, 2(2), 9-14.

Mitchell, P. (1998). Hits and myths. Safeguard: Journal of Occupational Safety and Health, March/April, 40-41.

Mortlock, C. (1983). The adventure alternative. Cicerone, Cumbria, U.K.

O'Shell, H.E., & Bird, F.E. Incident recall. National Safety News, October, 58-63.

Raffan, J. (1984). Images for Crisis Management. Journal of Experiential Education, 7(3):6-10.

Schulze, W.D. (1980). Ethics, economics and the value of safety. In R.C. Schwing, & W.A. Albers, Jr. (Eds.), Societal risk assessment. How safe is safe enough? (pp. 217-232). Plenum Press, New York.