Cor. 7

Reg. 9

FINDING OF CORONER UNDER CORONERS ACT 1988

I, E G Bradley, Coroner at Timaru hereby certify that at an inquest completed on the 30th day of June 2004, at the Courthouse, Timaru
(Building at which inquest completed)

having enquired into the time, place, causes and circumstances of how [redacted] Mountain Guide
(Name, address, occupation)

died. I found:

that deceased died at Aoraki Mt Cook Village on 31 December 2003 from cardiopulmonary arrest as a consequence of bilateral haemopneumothoraces and a ruptured aorta after having been struck by an avalanche while climbing Mt Tasman

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

see attached

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

Dated at Timaru this 30th day of June 2004

[signature] Coroner

** Delete if not applicable*

NOTE - This form, together with the depositions, the prohibitions on publication and, where applicable, a certificate of registration of death, must be forwarded to the Chief Executive of the Department for Courts by the Coroner completing the inquest.

INQUEST into the deaths of [redacted]

and [redacted] held at the Courthouse, Timaru on 30 June 2004

Present: Mr M R Radford for family of [redacted]

Senior Constable D Hansen for Police

Mr G Hasell as adviser to the Coroner

COMMENTS AND RECOMMENDATIONS:

I am extremely grateful for the detailed evidence and reports of all those concerned with uncovering all aspects of this tragedy which resulted in the deaths of three mountain guides and one of their clients when in a group of 6 comprising 3 guides and 3 clients all 6 climbers were struck by an avalanche on Mt Tasman on 31st December last.

The attraction of mountaineering is not only the spectacular scenery, remoteness and tranquillity of the mountains but the physical challenges and risks the activity presents. Clearly with this goes an acceptance of the dangers and at times that an injury or fatality may occur. The latter can be mitigated against by physical fitness, experience and training but no matter, as history shows, however experienced the party may be, Nature at a particular time and place can deceive even the most cautious.

In this case the 3 mountain guides, collectively highly experienced and capable, were deceived into believing that no risk from slab avalanche was present. I notice that another professional mountain guide [redacted] climbing with his client at the same time had previously discussed the conditions with the 3 guides now deceased. They had observed no recent significant avalanche activity, were satisfied with the conditions and he likewise had no doubts about proceeding to climb on 31 December 2003 on the route the others had taken.

As subsequent events proved, a combination of immediately previous variable weather patterns with the consequent precipitation, moderate but acceptable wind conditions on the day causing a degree of spindrift affecting visibility, partial and varying cloud cover with the consequent deceptive light conditions, all combined to hide the presence of the unstable snow pack which triggered off the avalanche. It would also appear that no signs of unstable snow conditions

were observed when establishing belay points prior to the avalanche. Had the risk of avalanche activity been prominent in the minds of the three guides it may have been that they would have spread their party out to minimise the risk of setting off an avalanche and the consequences if one occurred. They may also have taken extra precautions to ensure that any of the ropes did not cross other ropes. Whether care in ensuring ropes did not cross, or if all anchors at the top of the second pitch had been fully established at the time of the avalanche would have made any difference, is uncertain. These factors certainly need to be taken into account in assessing lessons to be learnt from this tragedy. Also reports produced in evidence indicate some disagreement as to whether any snow or ice anchor system in use today in alpine climbing is designed for or expected to hold the forces involved in such a snow avalanche. So I suggest that the following matters be considered for adoption into any mountaineering training programmes:

1. Guides and non guided climbers need to be continually aware of the potential for and the consequences of avalanches during the summer months at high elevations. Climbing practices should be examined and altered if necessary to take these risks more into account.

2. Climbers, guiding or non guiding, need to consider the additional dangers presented by multiple ropes of climbers in close proximity and take action to reduce this risk.

3. The NZ Mountain Safety Council and NZ Mountain Guides Association should look into whether current snow anchor and running belay practices in New Zealand are adequate and if not undertake a programme to improve them.

Mr Radford as counsel for the [redacted] family has raised several issues which are mainly covered by other parts of my Report but in respect of which more specific comments might be helpful:

(a) Were the weather conditions such that the dangers should have been recognised? As previously referred to, the weather conditions on the day hindered the recognition of potential slab avalanche. History records that in the past like and highly experienced guides have died in similar circumstances. Climbing is a high risk sport and dangers can never be totally foreseen or eliminated.

(b) Was the decision to proceed a prudent one? On the basis of what the guides could observe, yes.

(c) Was the equipment carried and used adequate in the circumstances? The equipment carried was in accordance with current training, mountaineering and guiding practice.

(d) Were the procedures adopted during the climb appropriate in the circumstances? On the basis of what the guides could observe, yes.

(e) Was the standard of training and competence of the personnel at a satisfactory level? Two of the guides were both well known throughout the international guiding community with extensive experience while the third, was an experienced guide under direct supervision of the other two guides. No evidence has been produced suggesting training and competence were defective in any way.

(f) Was the conduct of the guiding company appropriate in the circumstances? Presumably this refers to the guides themselves. In hindsight it would be easy to say that greater caution should have applied. Since so much evidence is based on supposition I would be wary of making such an assertion.

(g) What improvements, if any, can be made to the procedures carried out to ensure as far as is compatible with climbing, this type of event does not recur? It is hoped the recommendations made in this Report addresses this matter.

Mr Radford has also supplied comments from the family regarding their experiences in dealing with the aftermath of death. I propose to forward these comments to the Police and to asking them to respond to the family with a copy of their replies to myself.

Finally I note that 31 rescue and medical personnel and 7 helicopters including DOC, Police, Alpine Guides Ltd, Fox Alpine Rescue, St John's Ambulance, RNZAF Three Squadron and the Hermitage Hotel were involved in the rescue operations not only in respect of the 4 deceased and the surviving two in the group but in respect of four others on the mountain at the

same time. We the public owe them our deepest gratitude for their expertise, professionalism and ability to respond in a co-ordinated manner at short notice.

E G Bradley

Coroner

6/7/04