Program Ideas: HOW TO…

association for experiential education

…PREVENT FATALITIES (8)

Serious accidents are rare in well conducted Experiential Education (EE) programs, but a few catastrophic tragedies have taken place around the world. While the media has sensationalized these rarities, EE programs can learn important lessons (beyond critical risk management) and be guided to avoid future fatalities by actively learning and applying lessons from the past.

FOUR FOUNDATIONS

1. Deaths have unfortunately occurred when a known potential for death was tolerated or ignored. EE programs must consistently **hold a strict aversion to death** by making fatality prevention an overriding priority. Never trade this aversion off against other considerations. Do not use low probability of death as an excuse for half-measures.
2. Deaths are most common when responsible leaders do not **remain fully conscious and vigilant** to potentially fatal circumstances or dangers. Simply having sound judgment is not enough, even where key knowledge is acquired from past experience and believed from sources like maps, weather forecasts, climate records, and reconnaissance trips.
3. Deaths often occur in specific, recognisable, and local situations. Program trips must have leaders who **understand fatal dangers uniquely interact with a local environment** and can then make immediate decisions based on their observations of conditions and client behaviours in the field.
4. Deaths have occurred because responsible leaders failed to envisage what could go wrong or to recognise a situation as deadly. They were simply unable to imagine the worst, because they had never encountered it. Leaders must **have knowledge of past fatalities**. This can accurately be obtained by monitoring cases, discussing incidents, and studying lessons from past tragedies as unpleasant as this process may be to some.

FOUR LESSONS

1. **Experience is an unreliable friend** when it comes to fatality prevention. Experience contributes to program quality and general safety, but experience provides potentially false reassurance of a low fatal likelihood.
2. **A good safety track record is not evidence of sound fatality prevention**, because safety measures, effective for day to day operations, are not necessarily the same measures required to prevent a rare death.
3. **Fatality prevention requires valuable time and effort.** Often, enhancing prevention means diverting key resources that would otherwise be applied to program quality, although preventable fatalities can occur in well-run, successful, high quality programs.
4. **Fatality prevention does not amount to generalised over-protectiveness**. However, prevention expertly focuses on a relatively small set of recognisable circumstances and also employs key targeted measures.

PREVENTION

For practitioners who work in any facet of EE, developing expertise in fatality prevention, commensurate with their role, is **requisite and non-negotiable**. The implications of a careful review of fatality prevention measures will range from calm reassurance that the necessary measures are already in place to the weighty realisation that a program or component must be discontinued or urgently remedied.

Fatality prevention is highly feasible for most EE programs. With the benefit of hindsight, most accidental deaths can be prevented by staff actively seeking out, studying, reflecting upon, and discussing earlier incidents. Doing so may help ensure that "**this never happens again**."

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