

CITATION: *Inquest into the death of Zoe Stephanie Woolmer*
[2015] NTMC 025

TITLE OF COURT: Coroners Court

JURISDICTION: Alice Springs

FILE NO(s): A0021/2014

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FINDING OF: Mr Greg Cavanagh SM

CATCHWORDS: **Tour groups, risky behaviour, inappropriate tour guide training, photo opportunities at cliff edge, fall from cliff, tour operator's failures, park authority's failure to enforce conditions of permit**

REPRESENTATION:

Counsel Assisting: Kelvin Currie

Family of Deceased: John Stirk

Rebecca Gethen: Peter Little

The Rock Tour: Scott Henchcliffe

Parks and Wildlife

Commission: Michael Maurice QC

Judgment category classification: B

Judgement ID number: [2015] NTMC 025

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IN THE CORONERS COURT
AT ALICE SPRINGS IN THE
NORTHERN TERRITORY
OF AUSTRALIA

No. A0021/2014

In the matter of an Inquest into the death of
ZOE STEPHANIE WOOLMER
ON 15 JUNE 2014
AT KINGS CANYON IN THE NORTHERN
TERRITORY OF AUSTRALIA

FINDINGS

Mr Greg Cavanagh SM:

Introduction

1. Zoe Woolmer (the deceased) was 23 years of age. She was born 3 November 1990 in Stevenage, England to her parents Dawn and Steven Woolmer. She had completed an Honours degree in Human Resources at Portsmouth University in June 2013 and was on a travelling gap year. She was fit and healthy.
2. Zoe came to Australia in August of 2013 on a 12 month working visa. She based herself in Sydney and had part-time employment with a recruitment agency. She planned to continue travelling to New Zealand, Fiji and Malaysia before heading home.
3. On 14 June 2014 Zoe flew from Sydney to Alice Springs to take part in a tour of the Watarrka and Uluru-Kata Tjuta National Parks over three days with 'The Rock Tour'.
4. At about 5.30 am the next morning she and another 16 tourists were picked up by their tour guide in a bus and headed for Kings Canyon in Watarrka National Park.

5. They arrived at about 11.45 am and set off on the three hour Rim walk. It begins with a walk up 'Heart attack' hill. Shortly after, at Cotterill's Lookout, the guide showed the tour group how to slide to the edge of the Canyon on their stomachs so as to get a good view over the edge of the Canyon.
6. At about 2.30 pm the group arrived at the last lookout on the walk before the descent back to the bus. It is known as Kestrel Falls and during rainfall is the top of a waterfall.
7. About one metre below the top edge is a rock ledge. Over many years it has been used for 'fun photos' and selfies where the tourist appeared to be clinging to or falling from the cliff. In reality they were just standing or crouching on the ledge.
8. The tour guide demonstrated to the tour group the best and safest way of getting down onto the ledge for the photos. It involved first sitting on the top of the cliff and then twisting over onto their stomachs and sliding down until their feet were on the ledge. She warned everyone to be careful.
9. A number of the group got down onto the ledge for the photo opportunity. They did it one by one. Zoe was the sixth or seventh person to get onto the ledge.
10. She gave her camera to another woman and asked her to take photos. Zoe was talking about the best photos as she was getting down onto the ledge. However on getting to the ledge she stumbled backwards falling about 30 metres onto rocks below.
11. She suffered significant and severe injuries including skull fractures leading to bleeding of the brain, a broken back, fractured pelvis, sternum and right shoulder blade and died a short while later.

The Investigation

12. Detective Senior Constable Barrie Bahnert supplied a detailed brief of evidence to my Office arising from his investigations into Zoe's death. It was of a very high standard. I thank him for that.

The Rock Tour

13. The Rock Tour is a tour company set up on 5 June 2006 by its Directors Jolyon (Jo) George and Robert Cowan ("the Directors"). Mr George was a very experienced guide with 14 to 15 years' experience guiding in Central Australia and Mr Cowan was more managerially oriented having been the State Manager for Coca Cola from 1997 to 2001. He has a degree in Business Management and is Managing Director of The Rock Tour Company.
14. Since 2006 the Directors estimate that they have conducted approximately 4800 tours with 92,000 passengers. Prior to the death of Zoe they had not had a serious incident.
15. In 2014 they had 21 employees, 12 of whom were tour guides.
16. They have received numerous awards including the Golden Backpack Award every year but one from 2007 to 2014.
17. The company conducts one tour. It is a 3 day/2 night tour. It goes to Kings Canyon, Kata Tjuta (The Olgas) and Uluru.
18. They sought to promote themselves as a youthful, young company in part by having fun adventure photos on their website and Facebook page.¹

The Tour Guide

19. Rebecca Gethen was the tour guide for Zoe's tour group.
20. Ms Gethen provided frank and honest evidence to the coronial investigators on three separate occasions and gave evidence at the inquest. She was

¹ Transcript pp 146, 180

clearly deeply affected by Zoe's death and was still struggling to come to terms with it and the guilt she felt.

21. No one involved in the inquest suggested she was being anything but truthful. She told the inquest that she told her group about the hidden ledge at Kestrel Falls and demonstrated how to safely get down to it and took the 'fun photos' of the first few people who got onto the ledge.
22. She explained she did that because she was trained to do that by the senior guides of The Rock Tour Company. To appreciate the significance of the training it is important to note that:
 - a. this was the first tour guide position she had held;
 - b. she was previously a children's entertainer;
 - c. she had been trained over a period of about a month;
 - d. the training included providing to the group the opportunity for the 'fun photos'; and
 - e. Zoe's tour group was only the fourth group she had taken out where she was the guide.
23. When asked why she followed the training she was given when it was clearly against the safety signage seen both at Kestrel Falls and in the Park generally, she said:

I didn't think and I just wanted to get everything right. It was in the itinerary and I wanted to do a good job.
24. Ms Gethen arrived at The Rock Tour Company for the first time on the 30 April 2014 and was introduced to their operations. On the third day she was sent on a three day tour as a passenger with one of the senior guides. There was already a trainee guide on that tour and so Ms Gethen was very much one of the guests.
25. On that tour she observed the senior guide demonstrate to the tour group how to get to the ledge at Kestrel Falls and get the 'fun photos'.
26. She was sent on three more tours as a trainee with a senior guide Alec Finn.

27. On each of those tours Alec showed the tour group the ledge and how to get the ‘fun photos’.
28. He also demonstrated a way to see over the cliff edge at Cotterill’s Lookout by sliding on his stomach to the edge of the cliff and looking over.
29. Unfortunately, Alec wasn’t able to attend the inquest. He was in Germany at the time. He was willing to answer questions over the phone but at the appointed time the Court was unable to get a proper telephone connection.
30. However Alec did provide a statement during the coronial investigation. He was asked about getting photographs of people on the ledge. Initially, he seemed a little reticent. He said:

“... you would of heard of people that climb down on the ledge ... but it’s one of those things we don’t encourage people to ... do it or anything like that. Sometimes people if they have a look they might do it, but straight away your like ‘get back up here’ because obviously not, clearly not safe.”

31. A little later he said:

Ah like it’s a good spot for a photo if you want to make it look like that it’s like an adventure rock climbing style photo.

If you let people know that, to be careful they know it is only a small step down to it and they are ok, they’re to do it. Ah sometime, sometimes you do ah let them take a photo there if they want to, but it’s not like its encouraged to say ‘everyone line up and climb down and we’ll get a photo of every single person there.

32. Later Alec was asked whether Rebecca might have seen demonstrated on his tours a safe way to get to the ledge. He said:

Yeah she would have seen it. She would probably have seen it on like with me a couple of people have done it. She would of seen it with other groups, ah people there because yeah, it’s generally you do see it here and there as you go, as you go around.

Safety Signage at the Kestrel Falls

33. At the top of the falls is a sign titled “Cliff Safety”. Beneath the title are the following warnings:

“**WARNING**” (in red lettering)

“Stay away from the cliff edge”

“Do not take shortcuts”

“Stay on the marked track”

34. That signage was repeated at numerous locations around the Rim Walk.

The Ledge

35. The ledge from which Zoe fell is about 1.3 metres wide and three or four metres in length. It is not flat and angles slightly toward the Canyon.

36. Perhaps the more important feature is that the cliff does not have a straight drop between the top edge and the ledge. The cliff gives way below the top edge leaving what might better be described as a shallow cave, the floor of which extends out as the ledge.

37. There had been a death at that ledge on 29 March 1997 when Leigh Herringe a 23 year old English tourist fell. At the time he was not part of a tour. He was travelling with family and friends. Zoe’s fall from the ledge was the first since 1997.

38. There may well have been an attitude amongst tour guides and some tour operators that getting down onto the ledge for photographs was not dangerous.

39. That was the impression given by some of the guides giving evidence. All of those involved in the inquest had participated in taking groups to the ledge. Some had later decided it was dangerous.

40. What may not have been appreciated was that a person making their own decisions on dangers and risks is somewhat different than a guided tour where its members are encouraged to take risks. In a guided tour a person may well not make their own risk assessment and be influenced by others.

41. In my view the practice of guiding tourists to the ledge for photo opportunities is manifestly dangerous and was obviously so prior to Zoe’s

death. These life threatening dangers were elevated by encouraging the tourists to climb unrestrained over the rim onto a small underneath ledge with a sheer drop of at least 30 metres to jagged rocks below.

Warning of Dangers

42. The issue of taking tour groups to this ledge was similar to taking them to the edge of the cliff anywhere around the Rim Walk. In essence there was danger created and it was against the safety signage and conditions of the permit allowing tour groups into the National Park.
43. On 14 July 2010 tour guides of The Rock Tour Company were observed and photographed (by an off-duty Ranger) encouraging the tour group to lie down at the cliff edge for the purposes of a group photograph. Neither guide made any pretence at keeping the tour group away from the edge.
44. A letter was sent by the Department of Natural Resources, Environment, the Arts and Sport (“the Department”) to Mr George of The Rock Tour Company that same month. It said in part:

The guides ignored the safety signage clearly in place around Kings Canyon and put lives of your clients at risk ...

As the above matter may be considered a serious breach of your permit, it is requested that you address these issues as a matter of urgency and reiterate with your staff the importance of abiding by the conditions of the permit.

You are requested to provide a written response to the Commission within 14 days of receipt of this letter outlining why this happened and what steps have been taken to ensure this does not happen again.

45. On 12 August 2010 Mr George sent an email to the Department stating in part:

I can confirm that the tour guides in question ... have been spoken to individually. I have also taken the opportunity to speak to all of the guides that we employ in regard to this incident.

I sent a text message and email to all of our guides explaining that they must not let their groups go to the edge of the Canyon and that they must reinforce the safety signs around the walking track.

46. The particular behaviour of concern did not relate to the Kestrel Falls ledge. It related to the practice of people lying down and then sliding to the edge of the canyon.
47. That was the same behaviour demonstrated to Ms Gethen by one of the senior guides at Cotterill's Lookout which she then demonstrated to her tour groups. In Zoe's tour group there were only about five people that took the opportunity to slide to the edge at Cotterill's Lookout.
48. Also on 12 August 2010 Mr George had a conversation with the Acting Director of the Department. He said that all tour companies visiting Watarrka were leading passengers to the edge of the canyon (standing or lying). He felt the letter unfair when 'everyone was doing it'.
49. Shortly after, the Department sent a letter to all operators titled "An important reminder to all Tour Operators and Guides visiting Watarrka National Park". It stated in part:

In most instances we are happy to report the majority of visitors are under the direction of their tour guide, acting in a safe and responsible manner ... others however continue to put the safety of their clients and other visitors at risk. It is a timely reminder to all tour operators and guides to reinforce the following whilst conducting tours with the Park:

- *Don't risk your life to get the perfect photo! It is recommended that all visitors stay at least 2 metres from the cliff edge. Whilst it might seem like a safe alternative, crawling on your stomach near cliff edges could still result in an accident or death ... Remember that anyone can lose their balance at any time.*
- *Guides should strongly discourage their clients from going near the edge and inform them of potential dangers. Allowing this activity to continue may breach your company's Tour Operator Permit.*

50. Mr Donald Wait the manager of Wayoutback Australian Safaris gave evidence. He has been operating his tours since 1999. He received that letter.

51. He gave evidence that the practice of crawling to the cliff had been going on for a very long time. He hadn't been of the view that it was dangerous. However his guides stopped doing it after that letter.

The Fall

52. Ms Gethen demonstrated to Zoe and the other members of the tour group the way to get down to the ledge for the photos. It involved first sitting on the top ledge and then twisting over onto their stomachs and sliding down until their feet were on the lower ledge. She warned everyone to be careful.
53. A number of the group got down onto the ledge for photos. Zoe was the sixth or seventh person.
54. She got down as instructed, sitting on the edge and then rolling onto her stomach. She then put her left leg down and moved her body to put her right foot on the ledge. However her right foot didn't reach the ledge at the moment she anticipated. As the witness put it "she stepped on air".
55. Given that the cliff at that point curves into the rock face it is likely that as she gripped the top edge of the cliff her legs and feet swung inwards a little before the unexpected jolt on reaching the ledge.
56. She stumbled backwards reaching out toward the top ledge and then fell over before rolling onto a rocky protrusion below the ledge and falling about 30 metres onto the rocks below.

The Rangers

57. At the top of Kestrel falls is one of four Emergency Call Devices (ECD's) on the Rim Walk. Rebecca called the Rangers and asked her group to move back from the edge. She then ran between the ECD and a point on the cliff where she could see Zoe. She told Zoe not to move and said, "*Help is on the way, darling. It's going to be okay. I'm here. I won't leave you*".

58. Zoe looked up at her. She didn't say anything but was groaning. Rebecca continued to talk to Zoe and reassure her until a Ranger, Melissa Merry arrived 25 minutes later at 2.55 pm.
59. At the same time Melissa was walking to the top of Kestrel Falls two other Rangers, Michael Rawnsley and Peter Beddows were walking to the bottom of the Falls. Peter was about ten minutes behind Michael. He was on a day off but had heard the distress call and offered to bring the balance of the medical supplies.
60. Melissa assessed the situation, got advice from the Health Clinic on management of Zoe, and requested that The Rock Tour Company and Emergency Services be advised. She then guided the other Rangers to where Zoe had fallen. Due to the nature of the canyon Melissa was also required to relay the radio messages between the Rangers at the base of the cliff and the Health Clinic and she made sure supplies were sent down when needed.
61. The first Ranger to get to Zoe was Michael. He arrived at 3.20 pm. He found Zoe on her left side wedged between two rocks. His first impressions were that she had some broken limbs but his immediate concern was the blood matted to the side of her head and face. In his view the blood, bruising and swelling and her eyes in particular indicated that she probably had serious head trauma.
62. Zoe seemed to be partially conscious, trying to pull her hair from where it was stuck to her face and trying to sit up. However she seemed incoherent and was not responsive to verbal communication.
63. One eye was badly swollen and couldn't be opened. Her other eye was able to be opened a little and her pupil was already contracted and only responded marginally to the flashlight.
64. Zoe was in an awkward position with her hips higher than her head and Michael put his backpack under her head and shoulders in an attempt to open her airways.

65. He couldn't find a pulse in her wrist but found one in her carotid artery and then checked her breathing. It was very rapid and shallow and he could hear gurgling noises in her chest. He started her on oxygen.
66. At 3.35 pm, Ranger Peter Beddows arrived and Michael rang the Health Clinic to seek further guidance.
67. At 4.00 pm Zoe stopped breathing and there was no sign of a pulse. The Clinic instructed the Rangers to move Zoe to a flat area and commence Cardiopulmonary Resuscitation (CPR).
68. Zoe recovered a weak intermittent Carotid pulse but it was deteriorating. Peter thought that Zoe was "shutting down". By 4.20 pm she no longer had a pulse. Her pupil was dilated and unresponsive to light and she had stopped breathing.
69. The Clinic advised the Rangers to stop CPR at 4.24 pm. Peter held Zoe's hand and the Rangers talked to her. Peter said he did that as he didn't want Zoe to die alone.
70. A body bag was sent down the cliff and they put her in it to protect her from the insects and animals. By that time it was becoming obvious that Zoe was not able to be evacuated that night and the Rangers could hear the dingos in the distance.
71. However they were unwilling to leave Zoe in the Canyon alone and so made camp in the rocks, lit a fire and tried to sleep. They couldn't. By three in the morning they gave up and sat around the fire waiting for dawn.
72. At the Inquest the family expressed their appreciation to the Rangers for the care and the dignity they afforded Zoe. I also commend them for their compassion and actions on the night in caring for and staying with Zoe.
73. It was clear the death of Zoe significantly impacted the Rangers and I thank them both for reliving those experiences for the benefit of the inquest and in particular the family.

Photos at the Ledge

74. One of the issues in the inquest was whether the practice of getting the ‘fun photos’ at the ledge was peculiar to Ms Gethen and those that trained her or more widespread. The Directors said they found it difficult to believe the practice was widespread.
75. There was however a significant amount of evidence as to the practice by Tour Guides of The Rock Tour Company. Part of that was in the form of photographs taken at the ledge. The photos showed The Rock Tour Company guides in their tour guide uniforms involved in the ‘fun photos’. Some were seen pretending to jump off the cliff, pushing others off and the like.
76. Mr Cowan, the Managing Director of The Rock Tour Company was able to identify seven of his guides in the photos with tour groups at the Kestrel Falls ledge. The employment of those guides spanned a period from 2011 until 2014.
77. Some of those photos were published in the media shortly after the death of Zoe. Of those photos in the media Mr George said, “it ... brought to our attention that we were doing things that were dangerous”. He said, “we didn’t know this was happening at all until we saw it in the press”.²

The Guides

78. Alec Finn was still a guide with The Rock Tour Company when he spoke to the coronial investigators and conceded that he engaged in the practice of pointing out the fun photo opportunities at the ledge.
79. There was also evidence from former guides of The Rock Tour Company they had engaged in the practice of taking the ‘fun photos’.
80. Timothy Hall was a former senior guide at The Rock Tour Company. He started in 2007 and stayed for a period of about two years. He told his tour groups about the Kestrel Falls ledge and how to set up the photos there.

² Transcript p 146

81. Adam Cooper was another former employee of The Rock Tour Company. He started with The Rock Tour Company in 2011 and was there for a year. He was again employed for three months in the first part of 2014. He stated that he pointed out the ledge on his tours and assisted in taking the photos of the tourists on the ledge.
82. Speaking of the guides he said:
- So, not only were we working together but the tour guides were also living together ... in conversation these photo opportunities came up a lot. It was part of the trip, it was part of the walk. People would be proud to get the best photo of that area, of the Kestrel Falls area.*
83. Brett Darwen was an experienced tour guide from New Zealand. He has a Diploma in Advanced Tourism Management and worked as a tour guide in New Zealand for six or seven years. He started with The Rock Tour Company in September 2013. He was at Kings Canyon with another group when Zoe fell from the ledge.
84. He had taken tour groups to the Kestrel Falls ledge. He was asked whether it was part of his training. He said: “No, I didn’t get shown that ... but just being other guides from other companies as well as The Rock Tour guides seeing it, that’s where I learnt it”. He went on to say that he felt uncomfortable with it and soon stopped that practice.
85. Jason Wright was a tour guide with other tour operators for eight years from about 2007 (although did not work as a guide for The Rock Tour). He thought every guide that’s worked in Watarrka National Park would know about the Kestrel Falls ledge. Although he didn’t believe the practice widespread he said that numerous tour guides have taken their groups there for photos on the ledge and he had done it on a few occasions.
86. The Rangers from the Parks and Wildlife Commission were aware of the practice ‘anecdotally’ although they hadn’t seen it themselves.

The Rock Tour led Zoe to her death

87. The Directors of The Rock Tour Company attended each day of the inquest. Although apparently surprised by the evidence they did not dispute that Ms Gethen was trained to provide the photo opportunity on the ledge at Kestrel Falls by their senior guides.
88. I asked each of the directors of The Rock Tour Company the following questions:
89. To Mr George:
- Q. Do you agree putting aside whether you knew or not what was going on at Kestrel, that your company led her to her death?
- A. It does seem that way from the evidence.³
90. To Mr Cowan:
- Q. Uncomfortable it may be for you, but your company led her to her death?
- A. It's extremely uncomfortable to admit that, but it's certainly something that doesn't – it doesn't sit very well with me or Jo but no, certainly I would accept that.⁴
91. They were appropriate concessions by the Directors in the midst of what was a clearly a very difficult inquest for them. They endured hearing evidence from ex-employees. One or two of those ex-employees described them as “cowboys” in the industry and alleged that the Directors had personally encouraged the taking of the ‘fun photos’ on the ledge.
92. One witness said that the Directors encouraged the practice to portray that their tours were fun, a “point of difference”.
93. For their part the Directors denied they encouraged their guides to get the ‘fun photos’ at the ledge or had any knowledge their guides were leading groups to the Kestrel Falls ledge.

³ Transcript p170

⁴ Transcript p 209

94. What the evidence did show and that the Directors accepted, was that they should have known and had a duty to know.⁵ As to whether they actually knew I make further comments hereafter. There were certainly many indicators that it was happening.

Indicators -

The Photos

95. Taken from the Facebook page of The Rock Tour Company were photos of the Rock Tour Company guides in the ‘fun photos’ at Kestrel Falls in 2011 and 2014. Although the Directors had access to the Facebook pages and had the ability to alter the pages they both denied they were aware of the photos.
96. Taken from the Facebook pages of The Rock Tour Company guides were similar photos taken in 2011, 2012, 2013 and 2014. The Directors said they did not have access to those pages.
97. Of their own Facebook pages Mr George said many photos were posted by their customers and it was difficult to check them all. He said that if he had seen the photos, the guides involved “would have been sacked instantly”.

The Culture

98. The potential outcome of being “sacked instantly” does not seem to have been widely known or appreciated among those that worked for The Rock Tour Company.
99. For instance there was nothing to indicate that the employee with responsibility for maintaining the photographs on The Rock Tour Company Facebook page understood the gravity of the behaviour shown in the photos. To the contrary the photos were still on the page at the date of Zoe’s death.
100. The Operations Manager, Mr Telshow, didn’t seem to have that understanding either. When he found out about photos showing The Rock Tour Company guides taking ‘fun photos’ at the ledge he said to them “Guys

⁵ Transcript pp 162 - 163

don't do it". He thought after saying that they would have stopped.⁶ He said he didn't tell the Directors of the photos.

101. The guides themselves didn't seem to take any action to conceal the practice. They posed in photos at the ledge, posted them to their Facebook pages and passed on the practice in their training without any hint that it could lead to termination of employment.

102. When the Director, Mr Joylon was asked about the practice shortly after the death of Zoe, he said:

*"It's not part of my training program ... nah I mean it's an awkward one, it's one of those points that people do over the years take photographs ... it's never been part of our training to educate a guide to that ... a lot comes down to the guide and to the group sorry and it's extremely difficult, all of the we've had limited feedback to this ..."*⁷

103. When asked at the inquest what he meant by the words "we've had limited feedback to this", Mr Joylon indicated that he did not know what those words meant.⁸

104. It is plain that the answers given in the recorded statement are substantially removed from the concept of instant dismissal.

The evidence of the former employees

105. At least two of the former employees who gave evidence might well be described as 'disgruntled'. Timothy (Daniel) Hall readily admitted that he didn't get on with one of the Directors. His evidence was, in part:

On my initial meeting when I first arrived in Alice Springs after expressing that I thought the website photos looked great, the photos that I was shown from that were Kestrel Falls and also over the edge of the rim. That's when it was actually explained to me that Kestrel Falls had a hidden ledge you couldn't see from the point of view of the photographer and it was - I think it was described with the words 'that's our marketing point of difference and we want our guides to bring photos like this back'.

⁶ Transcript p 227

⁷ Transcript of recorded statement p 10

⁸ Transcript p 145

106. He said he was told that by both the Directors.⁹

107. Adam Cooper was another former employee who may also fall into the category of being ‘disgruntled’. He and the Directors were still in disagreement about the terms of his leaving The Rock Tour Company during the inquest. As to the photo opportunities at Kestrel falls he said:

Guides are actively encouraged (by each other and also office staff) to get the “coolest” photo taken at this site. This has been in the Rock Tour culture since I first started in 2011.

108. Because there was unhappiness between those witnesses and the Directors care must be taken in accepting their evidence. Other guides that gave evidence stated they were not asked to get ‘fun photos’ from the ledge or the Rim although some said that they were encouraged to get adventurous photos for promotional purposes.

109. It may very well be that the issue was not so much that the Directors sought the particular photos at the ledge but that they did not provide sufficient guidance as to the difference between ‘adventurous’ and ‘dangerous’.

Knowledge of the Dangerous photographs on Facebook

110. It is not at all clear that Jason Wright could be termed ‘disgruntled’. He had worked for many years as a guide for other operators but was employed by the Directors as the manager of the Rock Bar (a related business to The Rock Tour Company).

111. In my view he endeavoured to provide an accurate and honest account. After the death of Zoe he obtained copies of the photographs from The Rock Tour Company Facebook page relating to the Kestrel Falls ledge and other unsafe practices that had concerned him.

112. His motivation for obtaining those photos and giving evidence was that he had warned the Directors about a year before of risks he saw the guides taking (when looking at the Facebook pages). He did not say those warnings

⁹ Transcript page 66

specifically related to Kestrel Falls ‘fun photos’. He was however displeased his warnings were ignored.

113. Mr Wright left on good terms with the Directors and it was not put to him that there were any hard feelings or disgruntlement.

114. As to the Directors knowledge of what was on their Facebook pages he stated:

I can't say that I was ever looking over their shoulder while they were looking at their page directly but they certainly made it very clear to me in a number of meetings that they keep their finger on the pulse with all aspects of their business and watch all of the social media etcetera. They were always knowing exactly what was going on on my page as well as the business page, so one could only surmise from that that they certainly would have known what photos were going up if they were watching the page.

Adventurous or Dangerous

115. Mr George in speaking of a particular guide he thought started the ‘fun photos’ said, “the majority of the photographs we have seen in the paper have come from him and his actions, but it has all been apportioned to us. So you know, he worked for me for a very short period of time and he could not distinguish between dangerous and adventurous.”¹⁰

116. When asked whether he thought his other guides could make that distinction, he said:

I would like to think so ... I have no reason to believe that they would have had competitions to do that because they were trustworthy people who believed in bringing the group back ...

117. The evidence however is to the contrary. As Alec Finn said:

Ah like it's a good spot for a photo if you want to make it look like that it's like an adventure rock climbing style photo.

118. There is sufficient evidence that the Directors of The Rock Tour Company encouraged guides to get tour photos and that guides did not appreciate the

¹⁰ Transcript p 147

distinction sought to be made by Mr George between the taking of “dangerous” and “adventurous” photos.

119. That may well have been understandable given that there were photos of dangerous activities on The Rock Tour Company Facebook pages in relation to Kestrel Falls and the Rim.
120. There is sufficient evidence to suggest that if the Directors had paid any attention they would have known their guides were involved in those dangerous practices. In my view, to not know in those circumstances could only have been the product of wilful blindness.
121. That is to say, on all of the evidence, I find that at the very least suspicion would have been, and was, raised in the minds of the Directors in relation to the dangerous activities of their guides, and it was convenient for them not to resolve those suspicions.

Training

122. The training of the guides with The Rock Tour Company consisted of:
 - a. A number of days in the yard with the Operations Manager learning how do things like clean the buses, pack the bus and trailer, change tyres and drive the buses;
 - b. A number of familiarisation tours conducted by a senior guide. In Ms Gethen’s case that was four tours. However it was variable depending on the experience of the trainee;
 - c. Obtaining a senior first aid certificate;
 - d. Obtaining a Certificate III in “Research and Share General Information on Australian Indigenous Cultures” with the Alice Springs Campus of Charles Darwin University;
 - e. Reading through the Guidebook of The Rock Tours. It was in the buses and it was expected the trainees would read it while sitting in the passenger seat on the tours.

123. The form of the Guidebook at the time of Ms Gethen's training was not able to be ascertained. The Guidebook provided by The Rock Tour Company to the investigator had many documents in it that post-dated Zoe's death.

124. Nevertheless, there was nothing in the Guidebook or training received outside of the familiarisation tours specifically about Kestrel Falls and the ledge.

125. There was however a passage in the Guidebook (in capitals) that said:

EXPLAIN TO YOUR GROUP THAT THIS IS A GUIDED WALK AND THEY MUST FOLLOW THE GUIDE AND THE "BLUE ARROWS" AND STICK TO THE PATH AND GO NO CLOSER THAN 2 METRES FROM THE EDGE OF THE CANYON AT ANY TIME. THIS WILL TAKE YOU ON THE CLOCKWISE HIKE RETURNING TO THE CARPARK.

126. If read by the guides, the significance of that passage seems to have been either missed or not understood as applying to the practices of sliding to the edge of the Rim or utilising the ledge for 'fun photos', at least by many.

127. A number of the guides couldn't remember that being a part of the Guidebook and others had not read it as anticipated.

128. One of the significant problems was that there was no part of the training or operation generally where the Directors would see or hear what was being taught to their trainees and no way of checking that the trainees were learning what it was anticipated they would learn.

129. There has however been some significant changes to process undertaken by The Rock Tour Company since Zoe's death. The changes made are:

- a. A specific and qualified training guide has been employed;
- b. Mr George has taken a more active role in training the guides;
- c. A sign-off register is being trialled. It includes signing off that trainees have read and understood the permit conditions and agreements with

the Uluru-Kata Tjuta and Watarrka National Parks. Those documents are placed in the tour buses.

- d. The Tour Guide Employment Contract has been revised to include conditions:
 - i. Requiring a trainee to notify the Operations Manager if they feel that an experienced guide is breaching any of the rules and regulations of the Parks.
 - ii. Forbidding the posting of photographs to be posted to any social media with the authority of Mr George;
 - iii. Making it express that the Company has the expectation that the same rules and regulations for the Uluru-Kata Tjuta National Park will also apply to the Watarrka National Park;
 - iv. Guides will be required to sign off on various competencies.
- e. All tour buses have copies of the Notice from NT WorkSafe dated 7 August 2014 prohibiting any person from going within 2 metres of the edge of the cliff at Kestrel Falls.

Parks and Wildlife Commission

130. The Parks and Wildlife Commission were represented at the inquest and had a number of persons present during the whole of the evidence and submissions, including the CEO Mr Andrew Bridges and the Director for Central Australian Parks, Mr Christopher Day.

131. It became obvious at a fairly early stage of the evidence that the Commission had information that some tour operators were breaching the conditions of their permits.

132. They had sent the letters warning of the dangers in 2010 in response to that information, stating that the practice of taking tourists to the edge of the Canyon was dangerous and in breach of the permit conditions of the tour operators.

133. Thereafter the Commission received “anecdotal” evidence that tour groups were continuing those practices. However they did very little about that and have continued to renew all permits. The Commission appeared to have very few mechanisms for the collection of evidence or enforcement of the conditions of the permits.
134. In my view a permit or licencing system without mechanisms for enforcement is only half a system. Very little, if anything was done to dissuade tour operators and guides taking tourists to the edge of the canyon and to the Kestrel Falls ledge for the photo opportunities after 2010.
135. Certainly there was little evidence that the tour operators feared the removal of their permit. The Rock Tour Company made little attempt to ensure their guides were aware of the conditions of the permit and no attempt to ensure they abided by them.
136. However, the actions of the Parks and Wildlife Commission since Zoe’s death and during the inquest have been what might be expected of a responsible and proactive government Department.
137. By the fourth day of the inquest the Commission had developed what it titled the “Six Point Plan”. It was in the following terms:
- 1) *Amend the permit conditions to prohibit the use of photo’s depicting dangerous activities for marketing purposes.*
 - 2) *Amend the permit conditions for tour operators doing regular tours at Watarrka to require all tour guides operating in that Park to have completed an induction course conducted by the Commission;*
 - 3) *Amend the permit conditions for tour operators doing regular tours at Watarrka to require all tour guides sign an acknowledgement form before a Ranger or other officer of the Commission relating to their knowledge and understanding of permit conditions, heat management plan, park safety rules and their employer’s, and their own, obligations, including section 19(2), 28 and 29 of the Work Health*

and Safety (National Uniform Legislation) Act, and of the penalties that can be imposed for failure to comply.

- 4) *Monitor compliance of permit conditions by measures including the following:*
 - i. *Social media and web site monitoring*
 - ii. *Informal debriefing of park visitors;*
 - iii. *Using un-uniformed people to accompany or observe tour group activities.*
- 5) *When reports of conduct constituting breaches of permit conditions are received, initiating high level direct contact between Commission officers and permit holders involved to require them to immediately take effective steps to ensure there are no further instances of such conduct. Also, when such reports are received, notify NT Worksafe of the information obtained.*
- 6) *Sending a letter to all permit holders who conduct tours in the Watarrka National Park, informing them of a zero tolerance policy for breaches of permit conditions jeopardising the safety of tourists in the park and for using photographs depicting dangerous activity for marketing purposes. The letter will also remind permit holders of their duties under sections 19(2) and 27 of the Work Health and Safety (National Uniform Legislation) Act, as well as the penalties involved, and advising them that the Commission will pass on all reports of such activities to NT Worksafe for action by that regulatory authority.*

138. There was also another issue that arose in relation to the permits. Previously on the application for renewal of the permit there had been a question, “Has there been any incidences (sic) on the park? If so attach details ...”. After that were “yes” and “no” boxes to be ticked.

139. However on the most recent applications that question had been removed. There was no reasonable explanation as to why the question had been

removed. It is clear that in considering whether to re-issue permits there is a need to take into account the past performance of the operator and their employees and contractors.

140. Perhaps the “tick box” method is not the best way of achieving that, however its complete removal with nothing else to take its place is surprising and should be remedied.

141. Pursuant to section 34 of the *Coroners Act* (“the Act”), I am required to make the following findings:

“(1) A coroner investigating –

(a) a death shall, if possible, find –

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

(iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

142. Section 34(2) of the Act operates to extend my function as follows:

“A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated.”

143. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

“(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.

(2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

- (3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner.”

144. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

- (i) The identity of the deceased was Zoe Stephanie Woolmer born 3 November 1990, in Stevenage, United Kingdom.
- (ii) The time of death was 4.24 pm on 15 June 2014. The place of death was at the base of Kestrel Falls at Kings Canyon in the Watarrka National Park in the Northern Territory.
- (iii) The cause of death was multiple injuries from a fall of approximately 30 metres from a cliff to the rocks below.
- (iv) The particulars required to register the death:
 - 1. The deceased was Zoe Stephanie Woolmer.
 - 2. The deceased was not of Aboriginal descent.
 - 3. The deceased was a tourist.
 - 4. The death was reported to the coroner by Police.
 - 5. The cause of death was confirmed by post mortem examination carried out by Terence John Sinton.

Recommendations

145. I **recommend** that the Parks and Wildlife Commission implement as soon as possible the changes outlined in the Six Point Plan presented to the inquest.

146. I **recommend** the Parks and Wildlife Commission consider my comments herein (vide para 137 – 139) in relation to the form and content of applications for permits and renewal of permits with a view to improvement.

147. I **recommend** that The Rock Tour Company continue with the strategies presented to the inquest for the better control and understanding of their systems and improved training for their guides.

Dated this 25 day of November 2015

GREG CAVANAGH
TERRITORY CORONER