REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] 2. **Sports Camp Tirol** **Herzog-Friedrich-Strasse 26, Door 8** **6500 Landeck** **Austria**
1	**CORONER** I am Margaret J Jones, assistant coroner, for the coroner area of Stoke-on-Trent & North Staffordshire.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 3rd July 2012 I commenced an investigation into the death of John Lomas aged 22 years. The investigation concluded at the end of the inquest on 1st October 2015. The conclusion of the inquest was that Private John Lomas died as a result of drowning. The conclusion of the inquest was Misadventure.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was a serving soldier with 22 Close Support Squadron, 2 Logistics Support Regiment based at Princess Royal Barracks, Gutersloh, Germany. In 2011 he had passed a Joint Services Adventure Training Swim Test in still water but he had recently failed a Military Swim Test and his record had been marked up accordingly. On the 15th July 2012 he was deployed on a one week Adventurous Training Exercise which included white water rafting. Army General Administrative Instruction Volume 1 Chapter 18 states that non swimmers shall not take part in wet activities. A generic risk assessment for white water rafting was completed. Control measures were identified and implemented but did not identify him as a non- swimmer. At 1400 hours on the 21st June 2012 he was taking part in a white water rafting exercise run by a civilian company on the River Inn at Nesselgarten, Bavaria. The River Inn is dammed by a water company close to the raft launch site. There was no liaison between the rafting company and the water management company. A 'stowage discharge' by the water company occurred between 1300 hours and 15.30 hours on the 21st June 2015. The dynamic risk assessment carried out on the river did not identify a change in the river conditions. The raft exceeded the permitted number of persons in white water grade 4+ conditions which prevailed at the time. The boat was launched too close to a stopper and capsized within seconds of being launched. The deceased was pulled from the river at Nesselgarten but was unable to be resuscitated and he was certified dead at 1550 hours.

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. There had been no liaison between Sport Camp Tirol and the Army prior to the white water rafting Trip that took place on the 21st June 2012. No generic risk assessment had been provided to or requested by Sports Camp Tirol as a result there was a lack of understanding as to the suitability of soldiers to undertake he trip. 2. The lead guide and the raft guide did not correctly dynamically risk assess the river Inn on the 21st June 2012 at the point of departure of the trip. They did not recognise that the level of water had risen by one third in the hour preceding the launch resulting in white water of grade 4+. 3. The number of person in the raft exceeded that permitted for the white water grade 4+ conditions that prevailed at the time. 4. The raft on which Private Lomas was a passenger was launched too close to a stopper resulting in it capsizing within seconds of launch. 5. There was no preparatory training on a less challenging river. 6. There was no water confidence test. 7. There was a no safety kayak. 8. Although not considered contributory in this particular matter it was noted that the boat had faults which were identified at its last inspection which had not been rectified. 9. There was no obligation to liaise with TIWAG Water Company to ascertain when a significant stowage discharge would take place and TIWAG had no obligation to notify rafting companies downstream who might be affected by the discharge. (The last discharge had been two and half years prior to this incident.)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday 27th November 2015. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:- 1. [redacted] 2. Gesachaftsfuhrer, TWIAG-Tirol Wasserkraft AG, Energiedatenmanagement & Kundenservices, Salurnerstrasse 15/11, 6020 Innsbruck, Austria 3. Stadtgemeinde Landeck, Innstrasse 23, 6500 Landeck, Austria 4. [redacted] (widow of the deceased) 5. [redacted] (parents of the deceased) 6. [redacted] counsel for Captain Foster 7. [redacted] Government Legal Department 8. Chief Coroner

	I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.	
9	**DATE** 1-10-15	**SIGNED BY CORONER**