Richard Thomas Middleton
Assistant Coroner for The County of Dorset

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. British Mountaineering Council** **2. Royal Yachting Association**
1	**CORONER** I am Richard Thomas Middleton, Assistant Coroner for The County of Dorset
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** Liam Day Inquest opened on 5/7/16 Inquest heard at Bournemouth on 21/11/16
4	**CIRCUMSTANCES OF THE DEATH** Liam was a medical student at Southampton University where he was also a member of the University Moutaineering Club. He left his home address on 15/6/16 to go climbing and failed to return. An extensive search was undertaken along the Dorset coastline following the discovery of a car linked to him and the presence of a climbing rope at Collis Point. The deceased's kit bag was found in this area. The deceased's body was recovered from the water on 28/6/16. The pathologist gave a cause of death as 1a) Hypothermia b) Falling into the sea.
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. – Liam Day was an experienced climber. He appears to have become interested in a relatively new climbing phenomenon of Deep Water Soloing (DWS). There are inherent risks of falling when climbing and it appears that the view held by those pursuing DWS is that by climbing over deep water you will reduce the risks of seriously injuring yourself should you fall. This is true of the deceased as there was no trauma found to his body on examination. I found the following preliminary issues contributed to his death:- 1. He was climbing with no safety line 2. He was not wearing a lifejacket or buoyancy aid 3. He was not wearing clothing that offered no warmth in the water 4. He was not on his own 5. He had no means of requesting help such as a whistle, a waterproof phone or waterproof marine VHF radio 6. He had left no specific instructions as to where he was intending to climb and what time he would be home The main issue I wish to highlight are the dangerously low temperatures in coastal waters to those enjoying sports/pastimes/hobbies and who are unaware of the same. This is the reason I am including the RYA in this report.

The Coroner's Court, Town Hall, Bourne Avenue, Bournemouth, Dorset, BH2 6DY
Tel 01202 310049 | Fax 01202 780423

	During the course of the inquest evidence was given that the sea temperature on 15/6/16 was around 12-13 degrees Celsius. The deeper one descends into water the colder one gets. The surface of the water is cooled by sea breeze. This temperature is in stark contrast to the air temperature found above the water and to the core body temperature of someone carrying out physical activity above the deep water. The consequence of someone falling into deep water who is unprepared for such an eventuality is panic, shortness of breath. Individuals can experience Cold Water Shock Syndrome. The pathologist in this case explained how in a relatively short period of time (taking into account the presence of all factors detailed above) he died as a result of hypothermia. It is the speed with which one can succumb to such a condition that I wish to highlight.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. I would wish for this case to be circulated to your members to remind those who are already aware of the risks and to inform those ignorant of the same.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 27/1/17. 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 British Mountaineering Council, Royal Yachting Association. I have also sent it to [redacted] who may find it useful or of interest. 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	Dated 14 December 2016 Signature _____ Richard T Middleton Assistant Coroner for The County of Dorset

The Coroner's Court, Town Hall, Bourne Avenue, Bournemouth, Dorset, BH2 6DY
Tel 01202 310049 | Fax 01202 780423