REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. [redacted], Regatta Director, Cowes Week Ltd, 18 Bath Road, Cowes, Isle of Wight, PO31 7QN** **2. [redacted], Team Manager, Licensing & Business Support, Regulatory Services, Jubilee Stores, The Quay, Newport, Isle of Wight PO30 2EH** **3. [redacted], Head of Emergency Preparedness, Resilience and Response, Isle of Wight NHS Trust, St Mary's Hospital, Parkhurst Road, Newport, Isle of Wight PO30 5TG**
1	**CORONER** I am Caroline Sarah Sumeray, Senior Coroner for the Coroner Area of the Isle of Wight.
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 14th August 2018 I commenced an investigation into the death of Wayne Andrew ROGERS, aged 62. The investigation concluded at the end of the inquest on 6th March 2019. The conclusion of the inquest was "Accidental Death". The medical cause of death was found to be: 1a Drowning 1b 1c II
4	**CIRCUMSTANCES OF THE DEATH** 1) Wayne Andrew ROGERS was born on 23rd March 1956. At the time of his death he was 62 years old and was a retired Accountant.

2) On Friday 10th August 2018, Wayne Andrew ROGERS was participating in an R.S. Elite Class Race at Cowes Week in the Solent. Mr ROGERS was a very experienced sailor having sailed for approximately 50 years.

3) Mr ROGERS was a member of a crew of three in a boat called “Legs Eleven” with two other very experienced sailors. He was trimming the spinnaker sitting in the middle of the boat. The owner of the vessel was the skipper and the third member of the crew was navigating at the front of the boat.

4) The race commenced at approximately 11.05 hours. The weather conditions were forecast for the race to be 12-18 knots from the south-west. At the time of the incident, the recorded windspeed had increased to 26 gusting 29.6 knots.

5) The race commenced from the Royal Yacht Squadron start line in an easterly direction. Initially the spinnaker was set. As the race progressed on the course, the wind increased and became very gusty. There was one really big gust which caused the crew of the “Legs Eleven” to lose control when the boat broached. This caused Mr ROGERS to be thrown across the boat into the water. It is believed that this happened at 11.25 a.m.

6) When Mr ROGERS had been inside the boat, he was manually holding onto the spinnaker sheet which is a thick piece of rope used to trim the spinnaker. It is believed that Mr ROGERS was still holding onto this rope as he fell into the water.

7) At the point at which the boat broached, the skipper also partially fell into the water, but he managed to climb back into the boat. Once back in the boat, he tried to take control and stop the boat by turning into the wind, however he was unable to do so as Mr ROGERS appeared to be still holding onto the spinnaker sheet whilst in the water, thereby preventing the boat from manoeuvring.

8) The spinnaker sheet appeared to be fouling the tiller. The crew shouted for Mr ROGERS to let go of the rope, until they realised that it was, in fact, caught around his ankle, and he was being dragged behind the boat trapped by his ankle. Subsequent calculations estimate that Mr ROGERS was being dragged in this manner for approximately a minute before a member of the crew from another boat who had been racing and had spotted this incident managed to jump into the water beside Mr ROGERS and cut him free.

9) Immediate attempts to conduct CPR on Mr ROGERS were carried out. A Mayday call was made on the VHF emergency channel 16 requesting assistance for an unconscious casualty. A rescue rib arrived, the crew were in

	contact with the coastguard. Minutes later, the RNLI arrived and took Mr ROGERS back to Trinity Landing at Cowes. Mr ROGERS was subsequently transferred by emergency ambulance to St Mary's Hospital, Newport, where he was pronounced dead at 13.10 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) I was informed that during the course of Cowes Week Sailing Festival that there are approximately 7,000 competitors who travel to Cowes on the Isle of Wight to participate in the various events. In this instance, it was fortunate that an ambulance was available to convey the casualty to the hospital as an emergency. However, there are a finite number of ambulances on the Isle of Wight, and they are often overstretched to carry out routine work, without the possibility of an incident happening during this Sailing Festival. 2) During the course of the evidence it was discussed with the Deputy Queen's Harbour Master as to whether it would be a good idea for the organisers of the Cowes Week Sailing Festival to consider employing the services of a private ambulance service, such as the St John's Ambulance Service, and paramedics, to be on site at Cowes and available at the harbour immediately were there to be an incident involving any of the competitors from the Festival thereby making the event a safer one. 3) Having considered the report into the incident from the Deputy Queen's Harbour Master, I would endorse that consideration be given to the pre- positioning of Automated External Defibrillators (AEDs) afloat and ashore. 4) A review needs to be carried out of the Crisis Management Plan, with an emphasis on monitoring and recording of safety channels and manpower coordination for incident response. 5) A review needs to be carried out of the published list of mandatory safety equipment, including mention of readily accessible safety knives. 6) A review needs to be carried out of the criteria for abandoning racing in the event of a major incident.

	7) Consideration should be given as to the benefits and risks of using continuous sheets on the jib and spinnaker. This could be extended to several other classes of dayboat and dinghy which often adopt the same configuration.
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 9th May 2019. 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: [redacted] (Deputy Queen's Harbour Master). 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	 **H.M. Senior Coroner – Isle of Wight** **28th March 201**