Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 British Kite Surfing Association

1 CORONER

I am Jason PEGG, Area Coroner for the area of Hampshire, Portsmouth and Southampton

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 7th July 2020 I commenced an investigation into the death of Nicholas James O'BRIEN aged 50. The investigation concluded at the end of the inquest on 09 June 2021. The conclusion of the inquest was:

I a Delayed Effects of Head and Neck Injury

I b

I c

II

4 CIRCUMSTANCES OF THE DEATH

The deceased died on 30th June 2020 at Southampton Hospital, Tremona Road, Southampton, Hampshire. The deceased suffered traumatic injuries to his head and neck whilst kite-surfing off Calshot Beach, Hampshire on 28th June 2020. A gust of wind caused the deceased to lose control of his kite causing the kite rigging to became entangled in a radio transceiver fitted to the deceased's helmet rendering the deceased unable to depower his kite in consequence of which the deceased was pulled through the sea and across a spit of ground by his helmet.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

The deceased was under kite-surfing instruction on 28th June 2020.
A radio intercom device used to assist with instructing the deceased had been attached to the helmet worn by the deceased using an adhesive pad provided by the United States based manufacturers of the device.
The kite rigging became entangled around the device preventing the deceased from depowering the kite and causing the deceased to be dragged through the water by his helmet.
The device remained in situ.

The device was not secured in such manner that it was pulled off when the kite rigging became entangled around the device and exerted forces upon it.
This concern could apply to devices similarly affixed to helmets, for example, action cameras and awareness of such concern should be addressed.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you 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 4th August 2021. 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] – Brother of the deceased

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.

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Jason PEGG
Area Coroner for
Hampshire, Portsmouth and Southampton
Dated: 09 June 2021