Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Transport Secretary** **2 Associated British Ports** **3 British Marine** **4 British Ports Association** **5 British Standards Institution** **6 Maritime and Coastguard Agency (Coroner's Reports)** **7 Red Bay Boats LTD** **8 Royal Yachting Association** **9 UK Major Ports Group** **10 UK Harbour Masters' Association**
1	**CORONER** I am Henry CHARLES, Assistant Coroner for the coroner 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 25 August 2020 I commenced an investigation into the death of Emily Jane LEWIS aged 15. The investigation concluded at the end of the inquest on 31 October 2024. The conclusion of the inquest was that: On 22nd August 2020 the Deceased died at Southampton General Hospital, Tremona Road, Southampton, Hampshire. Earlier that day she had sustained upper abdominal when the RIB Seadogz, on which she was a passenger, collided with a buoy, projecting her forward into the extended handhold in front of her causing fatal injuries: the Deceased's liver was compressed against her spinal column leading to transection, along with contusion of the pancreas.
4	**CIRCUMSTANCES OF THE DEATH** On 22nd August 2020 the Deceased was a passenger on a RIB experience ride on Seadogz, a 600bhp RIB capable of speeds well over 40kts. Following high speed manoeuvres in Southampton Water, Seadogz passed astern of a ferry, went through its wash and struck a buoy at a speed of 38.4kts. The Deceased sustained the fatal injuries set out in Box 3. Seadogz hit the buoy because the skipper did not become aware of its proximity in sufficient time to take avoiding action. To leave matters there would omit the multifactorial issues affecting RIB design, operation, planning, and regulation that contributed to this tragic collision. The skipper had lost positional awareness in the moments before the collision. This was most likely due to a combination of being desensitised to the risk of high-speed rib operations and the high mental workload associated with operating Seadogz alone at high speed near other marine assets. It is highly likely that the skipper's decision to conduct the transit close to the ferry significantly contributed to his high mental workload and loss of positional awareness. The tasks associated with acting as sole watchkeeper, navigator and passenger attendant undoubtedly increased the skipper's mental workload: the Small Commercial Vehicle and Pilot Boat Code recommends an

	additional trained crew member as being fundamental to ensure safe operation of a high speed passenger RIB given the high mental workload of single-handed operation. The skipper's field of vision ahead was obscured by the passengers in front of him, the raised bow as the RIB planed at high speed, and when the bow rose and dropped having crossed the ferry's wake in the moments before the collision. Forward visibility complied with BS EN ISO 11591 - but the standard did not evaluate the effect on forward visibility of full loading of passengers with the craft at maximum running trim. The Seadogz seating arrangement provided inadequate passenger protection in the event of a sudden deceleration, the handhold for the Deceased inflicted her fatal injuries. The size of the passengers allocated to the bench seat, including the Deceased meant that they could not effectively brace themselves against forward motion. Neither the SCV nor the Recreational Craft Directive provided specific conditions or guidance re seat design or RIB protection. Had guidance in Maritime Guidance Note 436 (M+F) been followed this may have prompted the skipper to refuse the Deceased boarding. The skipper may have experienced a negative startle response when he suddenly observed the buoy ahead. It is likely that passengers became desensitised to the high speed close passing of navigation buoys and vessels, reducing their ability to alert the skipper to an impending hazard. The MAIB described the Seadogz's written risk assessment as cursory and generic, it did not consider the risk of impact or collision during a RIB experience ride. No safety management system with external review process or structured approach to learning from the RIB's previous accidents existed. Significant limitations existed in application of the SCV Code to high-speed passenger craft operators. The framework of licensing can be complex. ABP (the harbour authority) had not assessed the risks of high-speed commercial passenger craft operations in its area, there was no agreement between ABP and operators about maintenance and use of craft. ABP have taken mitigatory steps. MAIB describe the requirements and guidance for operators of commercial high-speed craft as "confusing and inconsistent" Further, "in the last 15 years, the MAIB has investigated numerous accidents involving high-speed passenger craft and made various recommendations to improve the safety of this sector. However, as yet, little has been done to provide proper protection to passengers and crew from these hazards that routinely result in life-changing injury, and occasionally death."
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) In the course of the inquest I heard evidence of multiple issues in relation to in particular (a) the high workload of piloting a RIB at high speed, particularly in the vicinity of buoys and vessels (b) loss of situational awareness (c) the improvement in safety of having a second crew member thereby providing an additional lookout and reducing the skipper's workload (d) forward visibility issues in RIBs complying with existing requite safety standards when passengers are being carried (e) issues as to safe seating and the need to mitigate the effects of collisions, noting in particular the injuries suffered by Emily Lewis (f) the need for risk assessments and safety management systems to be meaningful (g) limitations in applying the Small Commercial Vessel and Pilot Boat Code as annexed to MGN 280 (M)(Small Vessels in Commercial Use for Sport or Pleasure Workboats and Pilot Boats – Alternative Construction Standards) to high speed passenger craft operation (h) the potential benefits of an automatic identification system (AIS). There was also evidence concerning the way in which the revision of the codes of practice appears to have slipped back: the Maritime & Coastguard Agency now plan to go to consultation next year, then the RYA will respond. The MAIB describes current requirements and guidance for the operators of small craft as "confusing and inconsistent" and observe that there does not appear to be uniform approach to managing the risks associated with high speed rides. In the foreword to the MAIB report into the index collision it is stated: "… passengers in

	small high speed craft are very vulnerable to impact and vibration injuries. In the last 15 years the MAIB has investigated numerous accidents involving high speed craft and made various recommendations to improve the safety of this sector. However, as yet, little has been done to provide proper protection to passengers and crew from these hazards that routinely result in life-changing injury and occasionally death." My concerns relate to: a. Whether consideration should be given to licensing arrangements for port authorities and local authorities to achieve an early, uniform and comprehensible framework for the use of RIB craft on high speed experience rides, including crewing levels, manoeuvres, craft standards and risk assessments b. Whether interim measures should be considered to manage risks of high-speed RIB experience rides c. Whether the existing BS EWN ISO 11591 needs revision (or supplementing) to take into account the effect on forward visibility of passengers about RIB craft and whether any practicable retrospective steps can be identified to improve forward visibility on RIB craft d. The need for consideration of seat and handrail design : as well as the injuries sustained by Emily Lewis I note the MAIB's concerns about handholds for jockey seats e. The need to consider whether there should be provision of AIS for RIB craft to facilitate monitoring of RIB craft operations and intervention in the event of unsafe practices being identified f. The need to consider how timely and comprehensive review of MAIB recommendations can be achieved"
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 January 10th 2025. 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] **(Family)** [redacted] **(**[redacted] **&** [redacted] **)** **(MAIB)** [redacted] **(Insurers for Seadogz)** I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 15/11/2024**  **Henry CHARLES** **Assistant Coroner for** **Hampshire, Portsmouth and Southampton**