HRSA Monthly Report

August 2019

Stephen Worley
Fatality at the World Rowing Championship

The following appeared on the World Rowing website here.

On August 21 2019, around 1:15 p.m., a 33-year-old Belarussian para-rower capsized during training on the Linz-Ottensheim rowing course.

Para-rowing boats are equipped with a floating device on the side of the boat, a so-called pontoon, for stabilisation. The fixation of the pontoon was broken. The reasons for this are yet unknown and are currently under investigation.

Most likely, this was the reason why the boat capsized. The rower was still able to unfasten the safety belts at the seat and shoes to free himself. The on-water safety boats of the local fire brigade were close by and rushed to the location of the boat.

When the rescue boat with a lifesaver on board approached, the rower was still holding on to his boat but subsequently let go, sinking under water. Despite immediate rescue activities, the rower could not be found. The murky water at the location is approximately 2.40m deep with almost no visibility.

Rescue divers were called in and started an extended search. At about 4 p.m. the rower was found under water in close proximity to where the capsize happened. The doctor at the scene was only able to pronounce the rower dead.

There was a request, from a member of the British Rowing staff to review the guidance that we publish to ensure that it is complete and appropriate.

Section 6.2 of RowSafe contains guidance on adaptive rowing and there are links to other documents. RowSafe can be found here. There is also a section of the capsize drill video that deals with rowers with disabilities. I feel that this is sufficient but may revise this opinion once the results and recommendations of any enquiries into this incident are known.
Incident Reports in August

A rower in a 1x was overtaking a pair of slower 1xs. He did not see another 1x coming in the opposite direction. The 1xs collided and, upon impact, a bow ball was broken to reveal the point of the bow. This tore through the shorts of the sculler then punctured the upper calf/back of the knee, causing serious bleeding.

The injured sculler was transferred to launch and a tourniquet was applied. The sculler suffered an approximately 5cm long 2cm deep gash to the upper calf. He was taken to the nearest club where the wound was bandaged. He was then taken to A&E by ambulance.

The club will check the condition of its bow balls.

The treatment was discussed with the Honorary Medical Adviser, who advised that

- Tourniquets should only be used in severe life threatening bleeding (eg: partial or total limb amputation).
- Applying them to non-major bleeds can, in reality, increase the amount of bleeding as the restriction will occlude the venous return above the injury and increase the venous bleeding.
- To be effective a tourniquet has to be applied to stop all bleeding - this means tightening the tourniquet to a level where it can, itself, cause quite severe pain as it crushes tissue.
- Furthermore, obstruction of the arterial supply to the limb can lead to severe tissue damage and possible eventual loss of the limb.

So how should you manage a bleeding wound.

- The most effective treatment is the application of direct constant pressure to the wound - provided the pressure is maintained for a reasonable time this will stop most bleeding (don’t keep looking at the injury to see if it has stopped bleeding). It may sound simple but most surgeons use direct pressure to control bleeding during surgery.
- If direct pressure does not work then it may be necessary to apply some haemostatic gauze. Most first aid kits now contain Celox gauze or something similar. This should be packed into the wound or applied under the direct pressure dressing and the direct pressure reapplied

Tourniquets should only be used if the bleeding cannot be controlled by both the above. There is further advice on the control of serious bleeding here.
There was an incident in which a coach was thrown from a launch. The automatic life-jacket inflated, the kill cord was detached and the engine cut out. The Coach removed her wellington boots and the inflated life-jacket when in contact with the launch to enable re-entry to the launch. There was no injury sustained. The RYA has recently updated its guidance on kill cords and introduced a new video, this can be found here.

There was an incident in which, following a capsize of a fine 1x, the footplate broke making the heel restraint ineffective. Please remember to check the integrity of the footplate and when checking heel restraints.

There have again been several incidents where collisions have been caused by failure to keep an adequate lookout, such as an 8 colliding with the stern of a slow moving motor cruiser, crushing the first foot of the 8’s bow. Keeping a good lookout, particularly ahead is so fundamental that it is disappointing that it is sometimes done so badly. There have also been incidents due to the bad steering of motor boats.

A group of four young boys were verbally abusive to a crew in a coxed quad. One threw a 2 foot stick (1 inch in diameter) at the cox causing bruising to the top of her right arm. Another boat also received the same treatment with a stick being thrown at the young lady in the stroke seat. A member of the crew took a photo of one of the young lads; this has been passed to the police and the crime was recorded.

A dog ran out in front of a coach on a bike and hit the front wheel. The coach went over the handle bars and landed on the ground. The coach was taken to hospital and x-rayed; she suffered three fractures to her left arm and left wrist. Her right arm was cleaned of gravel and bandaged; gravel was also removed from her face. She has been unable to drive and has been signed off work. She has also needed massages to help treat the whiplash and damage to her shoulders and neck which have caused headaches.
Cardiovascular issues in Masters

Concern has been expressed by a retired medical practitioner about the recent cluster of fatal and non-fatal cardiac arrests in the area where he rows (most while rowing or just after; one on an ergo). In his experience, deaths while rowing have been extremely rare.

He wondered whether this little group was a statistical fluke and asked for the numbers of deaths reported in the last five years. The following information was provided:

There are very few reported fatalities associated with Rowing, or coaching, in the UK and the vast majority of these are associated with health (mostly cardiac) incidents. We analyse reported incidents each year and publish the result on the website. The data on fatalities is on page 15, this shows the following:-

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>number of reported fatalities</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

The incident in 2015 involved a coach who drowned (or died from cold water shock) when coaching at night on the Tideway. One death was of a 15 year old girl who died as the result of an un-diagnosed heart condition. Most of the remainder were people in their 50s or 60s or older, who died from a heart related problem. One of the fatalities was the result of an aortal aneurysm in a man (a doctor) in his late 60s who was aware of his condition but chose to continue rowing. We do not ask about the cause of death but can often infer it from the nature of the first aid treatment. People sometimes volunteer this information.

You probably know better than I do of the beneficial effects of rowing, particularly on heart health. We believe that these outweigh the risks.

I think that the series of incidents in your area is a statistical blip. It may be that the age range of people who row in your area differs from that in other areas. Our response to these deaths is to promote information and training on CPR and life support, recently by sharing information widely on the Resuscitation Council (UK) Lifesaver material (see https://life-saver.org.uk/).

I only know about those incidents that are reported but suspect that the majority of these incidents are reported. We try very hard to encourage the reporting of all incidents.

Achievements and Frustrations

There has been a request to members of the Sport Committee to provide a summary of “what you are proud of having achieved over the past four years (and perhaps a little on the frustrations)” My submission is included in Appendix 1.

Please let me know if you think that there is anything there that is untrue or misleading or misconceived. Or if there is anything significant that I have omitted. Please write to safety@britishrowing.org.
The length of trailers and driving licence requirements

There was a request for information on the permitted length of trailers and the licensing conditions. This is a subject that I know almost nothing about so I am reluctant to express interpretations of the requirements or to make any recommendations. The following information is taken from the government website.

The government advice on vehicle weights can be found at [https://www.gov.uk/vehicle-weights-explained](https://www.gov.uk/vehicle-weights-explained) and contains the following:

"**Maximum authorised mass**

*Maximum authorised mass (MAM)* means the weight of a vehicle or trailer including the maximum load that can be carried safely when it’s being used on the road.

This is also known as gross vehicle weight (GVW) or permissible maximum weight. It will be listed in the owner’s manual and is normally shown on a plate or sticker fitted to the vehicle.

The plate or sticker may also show a gross train weight (GTW), also sometimes called gross combination weight (GCW). This is the total weight of the tractor unit plus trailer plus load."

There is information on driving licence categories at [https://www.gov.uk/driving-licence-categories](https://www.gov.uk/driving-licence-categories), this includes the following.

**Cars**

**Category B - if you passed your test before 1 January 1997**

You’re usually allowed to drive a vehicle and trailer combination up to 8,250kg **maximum authorised mass** (MAM). View your driving licence information to check.

You’re also allowed to drive a minibus with a trailer over 750kg MAM.

**Category B - if you passed your test on or after 1 January 1997**

You can drive vehicles up to 3,500kg **MAM** with up to 8 passenger seats (with a trailer up to 750kg).

You can also tow heavier trailers if the total MAM of the vehicle and trailer is not more than 3,500kg.

**Category BE**

You can drive a vehicle with a **MAM** of 3,500kg with a trailer.

The size of the trailer depends on the BE ‘valid from’ date shown on your licence. If the date is:

- before 19 January 2013, you can tow any size trailer
- on or after 19 January 2013, you can tow a trailer with a **MAM** of up to 3,500kg

There is further information in section 7.2 of RowSafe, this contains hyperlinks to additional information.
Buoyancy Aids or Lifejackets

There has been some discussion on the merits of buoyancy aids and lifejackets. This included the following.

Buoyancy aids are usually used by people who expect to be in the water and people who often find themselves in the water (e.g. canoeists, dinghy sailors, sailboard and paddleboard users). Lifejackets are usually used by people who do not expect to enter the water but who may accidentally do so. Lifejackets are designed to turn an unconscious person onto their back and support their face clear of the water. In my view, buoyancy aids have no place in rowing.

Buoyancy aids must never be used by the cox of a bow loader as if the boat capsizes then the upward buoyancy force will hold the cox, underwater, in the boat. Coxes of bow loader should always wear manual inflation lifejackets.

Lifejackets do not last forever. They should all be checked, including an inflation check, at least once per year. If you are using old ones then it is particularly important that they are checked. There is a Safety Alert entitled Check your Lifejackets, here.

This topic is covered in RowSafe in section 7.3. Chapter 7 can be found at here.

Support for the Cornish Pilot Gig Association (CPGA)

There was an incident report that concerned a near miss between a gig and sliding seat boat. There was also an email from a person in Cornwall who had, some time ago, written to express concern about the unsafe behaviour at his local gig club. The latest note contained the following.

“I’m very pleased to write that the 'behaviour' of local gig rowers has improved radically this year. The boats no longer go out by themselves, don’t venture miles off shore or in the dark, instead they practise in pairs or more and keep to a route about 300m from the shore-line. I don’t know if boats carry lifejackets but as the water now is around 19C there’d be less shock if a boat capsized.”

Information on both of these communications was shared with the CPGA Safety Adviser.

Work with British Canoeing

An Incident Report contained the following:

“A group of about 10 canoeists attempted to overtake us on both our starboard and port sides, despite our boat being about one oar’s length from the bank. As a result, our oars clashed with two of the canoeists and we were forced to stop to avoid further collisions. All canoeists continued upstream without apology or interruption. The navigation of these canoeists was dangerous and aggressive; there was plenty of room on our port side for all of them to overtake. “

This incident was discussed with colleagues at British Canoeing and further enquiries were made to identify the canoe club involved. British Canoeing will discuss the incident with the club.
Safety Checks at Regattas

Concern was expressed that, the officials now ask if the crews whether they are satisfied with the safety of their boat, rather than personally inspecting the boats for safety. This was thought to be due to a concern about legal liability in the event of an official not identifying a defect.

Equipment checks are covered in section 7.2.8 of the Rules of Racing. I do not think that there have been any recent changes in the procedure or in this part of the rules.

I think that it is important to remember that crews, and their clubs, are responsible to ensure that the equipment they use is in good condition. They should not rely on people from outside the club to check boats for them but they should do it themselves. I would normally expect a coach to teach his or her rowers how to check a boat and for the rowers to do so at the start of every outing. If crews are not competent to check their own boats then the club should ensure that someone does it for them. I can think of very few circumstances (e.g. a rower having a serious sight impairment) where a rower who cannot check his or her boat should be entered into a competition.

I believe this to be a matter of personal responsibility that has nothing to do with personal liability. Please do not forget the "reasonable person" defence. If we all do what is reasonable in the circumstances and follow appropriate guidance, then we should not have any concerns about legal liability.

I do not think that boat checking at events and competitions causes delays so long as there are sufficient competent people to do it.

Please remember that the majority of our incidents are caused by at risk behaviour rather than by the condition of equipment. If all steers would keep to the correct part of the waterway and look where they are going then there would be fewer harmful incidents. In general I am more concerned about safety during normal club outings than I am during competitions. The level of supervision tends to be greater during events and competitions.

Some coastal regattas and their associations take great care to check all boats prior to launch and report defects found in Incident Reports. This is entirely appropriate in the conditions in which these boats are used and should be regarded as best practice.

Review of Safety Documents for British Rowing events

The Safety documents for the BR Offshore Championships and the BR Beach Sprints were reviewed and some opportunities for improvement were identified and recommendations made.

Alleged poor umpiring at a regatta

There was a complaint of poor umpiring at a regatta, this was referred to the Regional Chair of Umpires.

This report is a safety guidance document. Please read our safety message and disclaimer in RowSafe.
Appendix 1 - Achievements and Frustrations

Summary of my actions

I am very pleased that in the last four years:-

- **RowSafe** has been revised and is updated each year. Feedback on the content and format show that this is much appreciated.
- **Safety Alerts** have been introduced and so far 38 of them have been issued.
- The **Incident Analysis** has been conducted each year and this provides information that is used to drive improvements.
- **Monthly Reports** are produced and shared extensively, these are widely viewed as the monthly safety newsletter.
- The online Risk Management Training at **Basic, Intermediate** and **Advanced** level has been published
- **Guidance for Rowers and Canoeists on shared waters** has been issued jointly with British Canoeing
- Publication of the **Collision Avoidance video**, (also on the British Rowing website)
- Publication of the **Safety in Club Premises** guidance documents in Club Hub.

I have been pleased to represent British Rowing in dealings with the :-

- Maritime and Coastguard Agency (MCA)
- Marine Accident Investigation Branch (MAIB)
- Royal Society for the Prevention of Accidents (RoSPA)
- Royal National Lifeboat Institution (RNLI)
- Royal Humane Society (RHS)
- British Standards Institution (BSi)
- Fédération Internationale des Sociétés d’Aviron (FISA)
- British Canoeing and
- Cornish Pilot Gig Association (CPGA)

I believe that these dealings have enhanced the reputation of British Rowing.

In addition, I believe that my work with British Rowing has helped to deliver:-

- A network of people interested in safety
- Greater use of the Incident Reporting system
- Greater awareness of safety and safety improvements in clubs
- Greater acceptance and use of hi-viz clothing when rowing

*This report is a safety guidance document. Please read our safety message and disclaimer in RowSafe.*
Examples of other activities

The MAIB investigation into an Ocean Rowing fatality recommended actions to be delivered by British Rowing. As a result, discussions were held with representatives of the Ocean Rowing “industry” and RowSafe was extended to include Ocean Rowing. The MAIB wrote to say that it was satisfied that these actions fulfilled its recommendations.

A rower drowned at a FISA training camp in Africa and FISA asked that I investigate and provide a report. This was much appreciated by FISA. In addition, a mathematical exposition on the effect of footplate angle, heel restraint length and shoe size on the effectiveness of heel restraints was produced and a copy was provided to FISA.

There has been extensive work with the CPGA. This includes the extension of RowSafe to include Fixed Seat Rowing on the sea; RowSafe was subsequently adopted by the CPGA as its safety guidance. In addition, safety presentations have been delivered to over 60 members of the association prior to an AGM and to several CPGA Clubs.

There have been many requests for information and advice from members of rowing clubs (including some from outside the UK). Feedback shows that this advice is much appreciated.

The safety documentation for British Rowing competitions is reviewed and feedback is provided. The quality of this documentation has improved continuously.

Safety Workshops and on-site Safety Audits have been provided to some clubs; these clubs have subsequently expressed their appreciation.

The Performance of British rowers and clubs

I am pleased to report that there have been several incidents in the last two years when rowers have rescued people who could otherwise have drowned, these include rescues by:-

- a sculler on the Tideway - August 2017
- a coach from Westminster School BC - March 2018
- members of Worthing Rowing Club - August 2018
- members of Hatfield College BC and St Cuthbert’s Society BC (Durham) - February 2019
- members of the Royal Agricultural University RC - March 2019
- members of Boston RC – July 2019

The quoted dates refer to the monthly report that contains further information.
There have also been **no accidental on-water rowing related deaths** in British Rowing since 2015, (the previous ones were in 2005 and 2000) although there have been reports of deaths and near fatal incidents in other countries, including:-

- Fatality in Uruguay - February 2017
- Drowning in Ohio - April 2017
- The triple fatality at Arnhem - October 2017
- Ocean Rower fatality - December 2017
- Another fatality in the Netherlands - May 2018
- Drowning in Africa - December 2018
- Near Fatal incident in Ireland - February 2019 and June 2019
- Death of a para-rower at the World Championships in Linz - August 2019

The quoted dates again refer to the monthly report that contains further information.

**Subjective Impressions**

This is difficult to quantify but I have the impression that the severity of harm caused by incidents (particularly those on the water) has reduced and that the willingness of clubs to report incidents has increased. We provide rewards (certificates) and recognition (listed in monthly reports) to the clubs that report the most incidents. Most clubs understand that it is right and proper to report incidents as this helps us all to learn what does happen and how it can be avoided in future. This attitude to open reporting and information sharing is extremely valuable.

There seems to be an increase in the reporting of off-the-water incidents.

When I visit clubs (typically to do Coach Assessments) then I often see Safety Alerts and Health and Safety Policies (following the example in RowSafe) on notice boards. Some Clubs produce their own Safety Alerts. These are very gratifying.

I feel that the level of interest in safety has improved. This feeling is supported by the quality and quantity of correspondence I have with rowers and coaches. I feel that more people understand the need to be safe and take care to look after themselves and others.

**Working with the Staff**

Over the years, I have worked with many members of the British Rowing staff and have always found them to be highly professional and committed to their work. They work hard and have little time for activities that are not in their work plan. I too endeavour to adopt a professional approach to my work for British Rowing and value the opportunity to work as a “semi-detached” member of such an effective team. They are a delight to work with.

---

This report is a safety guidance document. Please read our safety message and disclaimer in RowSafe.
Working with the National Rowing Safety Committee (NRSC)

The NRSC is composed of people with an extensive knowledge of, and commitment to, rowing safety. We meet from time to time and some of us correspond regularly. As a group they tend to be strong on ideas and provide a useful link to people in their regions.

Working with the Honorary Medical Adviser

I am pleased to be able to consult with Dr Zideman as he always shares his extensive expertise in a very friendly and constructive way. I feel that we each appreciate each other’s contributions and that his advice adds considerable value to my efforts.

Frustrations

There are a few frustrations but, in time, I am confident that matters will improve. These frustrations can be summarised as follows:-

- Some rowers continue to row on the wrong part of the waterway and not keep a proper lookout. This is the cause of most collisions.

- I find it frustrating that I have not had enough time to complete the application for a Leisure Safety Award on behalf of British Rowing.

- I also find it frustrating that British Rowing and the CPGA have not yet been able to formalise their relationship. I have worked extensively with the CPGA and hope that they can see the benefits of a closer relationship with British Rowing.