Safety Report for NRC AGM December 2016

Club Audits
This year's audit had to be completed in time for me to review it by 30th November. So far, most clubs in this region had started their audits but the system made it possible to enter incorrect data in a key field. As a result, only 75% of the clubs have completed their audit. The remaining clubs have been given a link to correct their audits. I will discuss the audits with clubs at the Club Development Conference on January 22nd.

Incident Reporting
Only half the region's clubs have reported any incidents. That is unlikely to reflect reality! Please report any incidents as soon as they happen. If you do not report an incident, it may affect your ability to make an insurance claim for injury or damage.
Number of incidents reported in the region; Oct 2015 – Oct 2016 = 111
Number of incidents reported in the region; Oct 2014 – Oct 2015 = 131
Number of incidents reported in the region; Oct 2013 – Oct 2014 = 134

Collisions
The most commonly reported incidents, after simple capsizes (55), were collisions (26). Collisions were also the main cause of injuries and they are avoidable if crews follow the rules of the river and keep a good lookout. All crews should look around approximately every five strokes to ensure that there is nothing in their way. Also, if a crew is approaching you, call a warning; don't just sit quietly waiting to be hit.

Trailer Safety
This year I have been made aware of three potentially serious trailer incidents:

> Recently the drawbar of a trailer suffered a catastrophic failure; fortunately, at very low speed and away from other people. Examination of the drawbar revealed that a fatigue failure had been developing for some time (probably over two years) and the resulting crack would have been visible to anyone looking up at it from below. The trailer was over 12 years old and had been regularly serviced.
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> Another older trailer suffered a similar failure, again at low speed.
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> The third trailer had been parked on the bank on the Tideway and a very high tide had immersed the wheels in the river. Some months later the brakes were checked because they were dragging and the wheel bearings were found to be in such a bad state that a wheel could have come off on the road.

Routine servicing does not include the same checks as an MoT, which would have picked up these faults. I recommend that all trailers are given an MoT-type check annually after they reach three years old. The driver of the towing vehicle would have been held liable for any injury or damage caused by these incidents, had they happened at speed on a crowded road. The club would also be liable if regular servicing had not been carried out.

Risk Assessments
I have tried the new Risk Assessment format for 2016 and I have found it quite onerous. I believe that it is more important to produce useful rules and instructions for clubs and rowers from a simpler RA form. I am going to suggest, at the RSC meeting next weekend, that a simplified form is used by clubs and events. I will report back to the Executive next year on the outcome of our discussions.

Boat Maintenance
Clubs and crews are responsible for the maintenance of their boats. Bow balls, heel restraints, hatch covers etc. should be checked before each outing, whether training or racing. Umpires at events simply ensure that boats comply with the Rules of Racing; they are not responsible for a crew's boat maintenance.

If you want further information on any of the above, please contact me.

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Fatal Accident of Rowing Coach in Launch on Tideway

CAUSES

1. Mechanical Issues
Thames Rowing club run and maintain a number of TIN FISH coaching craft. The vessels undergo twice yearly in house checks and the outboard engines are externally serviced at the same time. Despite these checks, the issues with the interlock and throttle on the outboard engine could result in the outboard being started in gear and with significant throttle being applied.

2. Kill Cord
The evidence suggests the kill cord was not connected to the casualty as it was intact and remained attached to the vessel. This is supported by witnesses who observed TIN FISH 005 out of control and operating at speed. Had the kill cord been connected to the casualty then the vessel would have remained in close proximity to the casualty after he had entered the water.

3. Lifejacket
The body of the casualty was recovered from the water without a lifejacket. While colleagues have noted the casualty was a habitual wearer of lifejackets, there is no firm evidence to support the wearing of a lifejacket at the time of the incident.

4. Lone Working
At the time of the incident, the casualty was navigating TIN FISH 005 alone and not in close proximity to any other rowers or river users. As a result there were no witnesses to the event and therefore no one was able to render assistance to the casualty or raise awareness of the incident with emergency services.

RECOMMENDATIONS

Thames Rowing Club is recommended to:

1. Undertake a full review and assessment of all their outboard engines to ensure they can't be started in gear and that they are operating correctly. Further; additional checks should be implemented periodically to ensure outboard engines remain in a serviceable condition. *[Conclusion 1]*

2. Ensure that Thames Rowing Club Policy in respect of Kill Cords is adhered to fully by all club users that are permitted to use any vessel fitted with an outboard engine. *[Conclusion 2]*

3. Ensure that fully serviced and appropriate self-inflating lifejackets are provided for all club members using Tin Fish and coxes and that all club members are trained on how to wear and check the lifejackets made available. *[Conclusion 3]*

4. Consider restricting the lone use of both Tin Fish and Rowing Boats on the tidal Thames, during the hours of darkness, following this incident and the resulting risk associated with entering the water alone at night. *[Conclusion 4]*