Laura Rose Morgan – Findings and Verdict

On Monday of this week, I resumed an inquest touching on the death of Laura Rose Morgan – an inquest originally opened by Dr Nigel Chapman on the 8.8.2003.
I explained in full how it came to be that the matter is only now being explored in full, some 8 and half years after the event. I also set out, in brief, a summary of the circumstances of Laura's death. In the course of this week, there has been very full investigation into the circumstances of Laura's death in order that the court, and all interested persons could more fully come to understand the factual circumstances of how Laura died.

I have read the statements of the following 13 witnesses and considered their oral testimony:

Lynne Morgan – mother of Laura;

Molly and Sophie McCullough – friends of Laura's who were with her on the boat on the day of her death;

Peter McCullough – the father of Molly and Sophie McCullough – who witnessed events unfold from where he was located on the shore.

Tzeen Mears – now Cartwright – employed by Sunsail as an Activity Assistant at the time.

Benjamin Annetts – employed by Sunsail as a Water Sports Instructor at the time.

Stewart Edge – employed by Sunsail as a Water Sports Instructor at the time.

Michael Thomas – employed by Sunsail as a Water Sports Instructor at the time.

Matt West – the managing director of Sunsail Europe at the time.

Simon Lettern – the club manager of Turkish Sunsail at that time.

Kevin Michael Jones – the Waterfront trainer employed by Sunsail at the time.

Rebecca Morgan – the Watersports manager by Sunsail at the time.

David Richie – an expert witness to the court. Mr Richie was originally instructed in 2004 to provide advice on the precise circumstances of this case.
At that time, he had responsibility for inspecting safety standards of training centres for the Royal Yachting Association. Mr Richie continues to advise the Royal Yachting Association on safety standards and regulations. He has published widely on this topic and is regarded as an expert in these matters nationally and internationally.

I have also read and considered the statement of Colin Bradley dated the 19.11.2003. Mr Bradley was also employed by Sunsail as a Watersports Instructor at the time.

I have therefore considered the evidence of 14 witnesses in the course of this week.

At the start of the week, I made the following observations, which in my view warrant repetition at this final stage of the investigation. The circumstances of Laura Morgan's death had far reaching effects in a variety ways – I shall explore at a later stage lessons learnt and changes in practices introduced after Laura's death. However, the impact in human terns has been life changing for many – very obviously for Laura's family and friends but additionally for all of those involved on that day. This week has been the first occasion when many of those immediately involved have been required to recollect and recount the details of what happened on that day. It was abundantly clear to me that they too have struggled to come to terms with the events of that day over the 8 and half years.

Without exception, I find that every witness who gave evidence to this court did so in order to help me formulate a clear picture in my mind of events as as they unfolded that day. Without exception, I find that all of these witnesses were honest and credible. It is not surprising that with the passage of time, and the trauma of the experience, they were occasionally unable to remember certain details – it is not surprising that on occasion, the accounts of witnesses were not consistent with their previous statements or with the accounts of other witnesses on the same issues.

I remind myself that honest, credible witnesses, however compelling, may often be mistaken and therefore unreliable. Some of these now adult witnesses were children when their statements were taken. All of the witnesses will have rehearsed these events many times previously to try to make sense of matters in their own minds – I have no doubt that this was done informally with other witnesses directly involved in the case. Other witnesses have given accounts formally in other courts. Excluding as I do, any attempt on the part of any witness to do other than to tell me the truth, the whole truth and nothing but the truth, I nevertheless find that there is a high risk of contamination of evidence – I have therefore considered that accounts given closer to the event are more likely to be reliable – where there have been inconsistent accounts given on significant issues, I have tried to ensure that there is corroborative evidence before making a finding of fact. It has not been an easy task for me for all of the reasons just given. There are some questions that cannot be reliably answered but having considered all of the evidence, I can find the following:

- In 2003, deaths resulting from entrapment when a trapeze was being used were virtually unknown. The risk of this happening was therefore reasonably considered to be extremely low.

- In 2003, the Sunsail Club took advice and guidance from the Royal Yachting Association on all matters relating to the sailing activities and facilities provided at the Vounaki resort. I find that there were no breaches of the safety regulations that applied at that time.

- The RYA guidance then and now is that the club holds responsibility for the safety of all guests engaged in water activities. Those who held managerial roles at that time accepted this.

- I specifically find that there was no requirement to ensure that the Hobie Catamaran should have been equipped with a masthead float. I do find that if there had been a masthead float on the boat, it would have reduced but not eliminated the risk of inversion after capsize and Laura might not have become entrapped.

- I find that although Laura was not an experienced sailor, she did sail a catamaran on 2 occasions before the afternoon of the 31.7.2003. I find that on all occasions that Laura was permitted the use of a catamaran, she was accompanied by Sophie and Molly McCullough who did have considerable experience of sailing. I find that this was considered a safe practice by the RYA at the time.

- Laura was permitted the use of a trapeze harness whilst sailing the Catamaran on the afternoon of the 31.7.2003. Laura had never before used a trapeze harness. Procedures at the time provided that persons with no previous experience would be briefed on land. I find that there was no proper enquiry made to establish if Laura had prior experience of using a trapeze harness before she was allowed to go on the water. I find that Laura had no instruction on the use of a trapeze from someone trained and qualified to give that advice and guidance.

- I find that on the afternoon of the 31.7.2003, Laura had an enjoyable time sailing with her friends for approximately 30 minutes. For reasons that are not entirely clear, but are most likely to have been due to a combination of factors, the catamaran capsized. I find that a rescue boat was in attendance within a matter of seconds.

- It quickly became apparent that Laura was unable to detach herself from the trapeze harness. I find that the rescue efforts from this point on were entirely in line with the training and advice given at that time. Before the rescuer had the opportunity of attempting to undo the harness, a gust of wind caused the capsized boat to completely invert and Laura was submerged. I find that all of those who were involved in the rescue at this point were appropriately trained, appropriately equipped and had considerable sailing experience. I do not find that there was any undue delay at any point. However none of those in attendance were immediately able to release Laura from the trapeze harness. The reason for her entrapment was unclear at the time and remains so.

- I find that all resuscitation efforts were conducted appropriately whilst on the sea and on land. The local emergency services were contacted at the earliest opportunity and pending their arrival, resuscitation efforts were continued on the beach by qualified staff and medical professionals who volunteered their assistance. Tragically their efforts were in vain and Laura was pronounced dead later that day in the local hospital. A post mortem examination conducted in Greece established that the cause of death was drowning in seawater.

- I find that Sunsail introduced immediate changes in the days following the incident and thereafter. I do not propose to set these out in full but they include parental consent forms for those under the age of 16 to confirm many details, including the previous experience and competence of the child. The children wear a coloured wristband according to the grading that is given to the child. Staff can easily identify which activities and equipment would be safe for that particular child. Rescue boats contain additional equipment including a snorkel and mask. Knives are now safely carried strapped about the person of the rescuer.

- In the years that have followed, many changes in practices have been introduced through the Royal Yachting Association. Reference was made to these in the course of the proceedings and I am told that if future changes are suggested by Mr Richie following this inquest, as they are likely to be, Sunsail will continue to adhere to these guidelines and implement them in full.

Taking account of all of the matters that I have addressed and in light of the findings made, I consider the most appropriate verdict in this case is a narrative verdict and my verdict is as follows:

Verdict

In July 2003, Laura Rose Morgan drowned whilst on a sailing holiday in Greece. On the afternoon of the 31.7.2003 Laura went sailing with 2 friends on a Hobie Catamaran boat. At the time, Laura was using a trapeze harness. After approximately 30 minutes, the catamaran suddenly capsized and subsequently inverted, causing Laura to become entrapped underneath the boat. Laura was an inexperienced sailor and she had never previously used a trapeze harness. No suitably qualified professional had advised Laura on the use a trapeze harness prior to her taking to the water that day. The rescue team attended immediately and despite their very best efforts, it was not possible to save her life.

Mairin Casey – 20.1.2012

HM Coroner for Nottinghamshire