

## **Fatality, Yarmouth Harbour, 12 August 1979**

The following are attached: the reports in the County Press and the Lymington Times, the Captain's statement and Coroner's summing up, the report of the investigating police officer and the post mortem examination notes.

The boy, handicapped but a capable swimmer, was wearing a lifejacket. His companion in the 8' plywood rowing boat was also a capable swimmer but not wearing a lifejacket. She survived despite being sucked right under the ferry; his trunk was severed and one leg chopped off at the knee. Most of the upper part of his body was not recovered. The dinghy was also chopped up in the accident.

It is plain from the witnesses' statements, and the investigating officer's report, that both were sucked underwater by the ferry's motion, having been swept into the bow area by the tide. Linda Powell, the woman on board the dinghy, said she jumped out of the dinghy and tried to jump clear of the ferry but "was sucked under water under a lot of turbulence". She describes being able to look up and see the underside of the ferry, before being scraped along it.

The inquest found a verdict of misadventure, based on the fact that the rowing boat's occupants were not really capable of controlling their boat, didn't understand the tide etc. In fact the ferry set off without the captain seeing them, when they were only ten yards from the prow. This was due to the fact that they couldn't be seen from the bridge and the crewmembers who did see them were unable to contact the captain in time via the tannoy, as he didn't answer it. The rowing boat had been in the vicinity for several minutes before the ferry set off, indeed several boats had tried to tow them clear of the harbour entrance. The captain was unaware of the accident until passengers managed to notify him some time afterwards. By this time the woman had been rescued from the water.

The initial suggestions that the captain had been drunk were dismissed by the police. He was drunk by the time he arrived in Lymington (but not in charge of the ship by that stage), having consumed 8 measures of brandy to calm his nerves after the accident, but had only had 2 pints 4 hours earlier when he was on duty.

The Coroner stated that a platform should be rigged at the bow and the Jury, reinforced by the solicitor, recommended that two persons should be present observing the bow and communicating with the Captain. It appears that these recommendations were partially accepted and it is understood that a single lookout is posted on the C-Class ferries. There is no such facility evident in the design of the new W-Class. It is worth noting that legislation since this fatality has emphasised the importance of recommendations from a Coroners Court. To comply with the coroners ruling the new W Class should have been designed with forward and aft observation platforms and prevention of foot passengers blocking the view from the bridge.

One crew member said, and the captain agreed, that passengers on the sundeck obscure the view from the bridge [effectively raising the visual horizon by 5-6 feet].

LM & KAH  
27 October 2008

## **Fatality, Yarmouth Harbour, 12 August 1979,**

### **Relevance in Lymington for the Proposed Introduction of Much Larger Ferries onto the Lymington - Yarmouth Route**

Since there has not been another incident of the seriousness of the August 1979 fatal accident in Yarmouth Harbour, it can be concluded that whatever actions were taken at that time have been sufficient. The tidal conditions, particularly during an ebb tide at Yarmouth are not relevant to Lymington where the tide flows along the river channel with a speed not much in excess of ½kn and the ferry terminal is not in as prominent position as in Yarmouth.

The Yarmouth accident raises the question of whether the W-Class ferries are likely to create a greater hazard from the point of view of serious or potentially fatal accidents in Lymington River than the C-Class ferries. The subject should have been central to the work that BMT Seatech carried out for the LHC as their Phase 1 study in February 2008. They found that the probability of the following

1. person in the water hit by ferry
2. person in water sucked into thrusters
3. boat (moored or moving) hit by ferry
4. junior sailors pass into wind shadow in Horn Reach

was so incredibly small that it was many times less than the probability of the ferry being sunk by a collision in the Solent! They do not explain the magnitude of the probability of their ranking or how they reached these conclusions. The final column in the BMT Risk table "Risk after control applied" finds the new ferries either similar to or safer than the existing ones. This seems to defy logic and is not explained.

The Yarmouth tragedy demonstrates two problems which ferry masters have to contend with:

- small craft that are in close proximity
- the lethal danger from the Voith Schneider propulsion units.

It is noted that the victim was sucked into the propulsion unit from the bow and not from adjacent to the thruster on the port bow, this is probably why the woman survived. Thus the new ferries with their larger central thrusters closer to the bow will be significantly more dangerous.

To examine the potential dangers in the Lymington River, as examples, three scenarios are considered, clearly a comprehensive analysis would need to look at all possible scenarios.

- A. A squall passes through when a number – it could easily be 10-20 – sailing dinghies are in Horn Reach and approaching or waiting to land at the slipway. The dinghies will typically be scattered on both sides of the river, in locations dominated by the tidal conditions. Any visitors will probably never have been in the immediate vicinity of such large manoeuvring craft as the ferries, there are very few locations in the UK where this happens remotely approaching a proportion of the 22,500 movements each year.

The wind disruption (up-wind as well as down-wind will be much greater for the new ferries (effects ~3x the ferry height up-wind) both in magnitude and period. This means that essentially all sailing craft will lose all means of propulsion to a much greater degree, even without the water flows which are being found to turn even quite substantial craft through 180-360° (in calm conditions). If the strong gusts (could be 30-40kn) are across the river – from the SW, the ferry master will have to use rapidly changing and very substantial amounts of power as gusts pass through, exacerbated by the buildings on the W side of the river.

The C-Class ferries are much more sheltered from gusts due to their much smaller central superstructure and the magnitude of the difference in the gusts is likely to be significantly greater than the 240% windage force on the W-Class ferries<sup>1</sup>. The ferry thrusters will be predominantly required to hold the ferry in the channel, requiring a substantial proportion of their 3x engine power. A number of dinghies on both sides of the ferry will be expected to be in serious difficulties – even if the master can see all of the craft, very unlikely due to the remoteness of the bridge, the size of the vessel<sup>1</sup> and the number of craft at risk. Does the master turn off the thrusters very rapidly<sup>2</sup> to avoid sucking dinghy(s) and sailors to their inevitable death in the thrusters and allow the ferry to be blown over dinghies on the leeward side trapped between the ferry and the moored boats? Multiple fatalities must be a credible possibility; reading the LHC booklet will be of little help. It is noted that the new ferries are fitted with a basic CCTV system – it is evident that this has not been designed as a safety aid and falls very far short of this; its use as a safety critical system is not credible.

- B. It is understood that the ferries are using their forward propulsion unit in the river to provide the forward power while avoiding substantial backwash but in total disregard to the damage to the river bed. If this is the case, the bow of the ferry is potentially very dangerous, primarily because the bow thruster will probably create little or no visible disturbance (accelerating water, for example before a weir or into the undertow around rocks on a beach, appears smooth) but will be lethal for any small craft or person in the water. Anyone unfortunate enough to be in this position will not get pushed along the side of the hull, they will be drawn down and killed with virtually no hope of survival<sup>2</sup>. A wide range of circumstances can create the precursor to such an event, anywhere in the river. The master has a very poor view of the close surroundings forward of the ferry<sup>1</sup>, and as they will confirm, other river users often (probably on a number of times each day at busy times) create situations which attract the attention of the master who could easily miss noticing another craft getting into difficulties – probably due to no fault of the ferry other than its presence in the river.
- C. The new ferries create a greatly increased side-wash from their propulsion units which is evident when the ferries turn, as they do at each of the bends in the river, or in windy conditions all along their path. It is already proven that even quite large craft will lose total control due to this or due to the backflow – sufficient for them to be run down by another larger craft probably going in the opposite direction to the ferry; this craft would not necessarily have the time or the space to take avoiding action. The consequences are a matter for speculation.

These examples identify risks for both ferry designs. They should be sufficient to demonstrate that, far from the BMT claim that the new ferries are no more dangerous than and often safer than the existing ones, they present a potentially much greater safety risk to small craft and their occupants in the Lymington River. This must be rigorously examined before it has to be done in a Coroners Court or by a QC in a major civil damages litigation. In the event of a tragedy, the first responsibility as far as the ferry is concerned will rest with the Master. However, if it is found that the risks of operating these ferries have not been properly assessed, the possibility of Corporate Manslaughter is likely to be considered.

Let us ensure that Alexander Thomson did not die totally in vain.

KAH 4 November 2008

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<sup>1</sup> <http://www.lymingtonriver.co.uk/Ferry%20Dimensions%202.0.pdf>

<sup>2</sup> A risk control measure claimed by Seatech, but an eternity for anyone in the water since it is understood that “instantaneous” means 15 seconds to de-clutch, but the thrusters will still be rotating. It will take about 1 second for someone to be sucked from the bow to the thruster, perhaps a second or two more for one which is not “thrusting”.

alcohol. Captain Cudlipp is a native of the ...  
has an accent which is naturally slurred, and at times rather  
difficult to understand.

From all of my enquiries, I am perfectly satisfied that at the time  
of the incident Captain Cudlipp was not drunk, and that the only alcohol  
he had consumed was two pints of beer at 1 p.m. that day.

GORDON HAROLD CUDLIFF upon Oath said :

H.M. Coroner: At the time of this disaster you were the Captain of the "GENWULF"?

Yes.

H.M. Coroner: We have been into it pretty fully but there are certain questions one  
cannot avoid asking and that is the matter that I am concerned about is  
the question of your look out from the bridge because as I think I mentioned  
earlier to the Jury we are not here to determine the question of civil  
liability but to find out how, when and by what means the deceased came by  
his death and to make, if we can, <sup>any</sup> suggestions to prevent such a disaster  
happening again. I went aboard a sister ship of the 'GENWULF' yesterday  
in Fishbourne and I appreciate the problems that you have. Coming to  
<sup>where seems to be some confusion</sup>  
this particular question, /what lookouts do you have ?

We only have one. There is normally only one except if there is fog.

H.M. Coroner: So when you are getting under way you just have the two of you on the  
bridge ?

Yes.

H.M. Coroner: And you, as I have been told, once you get on the bridge you take the  
helm until you are clear of the harbour ?

Yes.

H.M. Coroner: And the other one is, presumably, the look out ?

Well, some of us have different systems. What I do is the ..... man  
is the wheel man but he acts as a look out until the wheel man comes up.

/You

H.M. Coroner: You were in court when you heard one witness say that he had seen the dinghy out of control just coming round your port side and he hailed the bridge and he said there were three people on the bridge. That was incorrect ?

Yes.

H.M. Coroner: And he said he hailed the bridge three times and the third time you acknowledged. When was the first time you thought something was wrong ?  
When I saw the people waving.

H.M. Coroner: Were you under way then ?

Yes.

H.M. Coroner: Was there an exceptional lot of traffic about at that time ?  
Not for that time of the day or for that time of the year.

H.M. Coroner: If you get under way you have got no means of knowing whether there is anything immediately under the bows of your ship, have you ?

No.

H.M. Coroner: The people on the jetty - do you never get them to co-operate to say whether you are all clear forward ?

He did not tell me. It all depends on the position of the dinghy.

H.M. Coroner: It seems to me that someone could get under the bows of the ship without your being able to see ?

Yes.

H.M. Coroner: Would it not be possible just on either the port or the starboard side of where the ramp goes up - I know you cannot see from there as it now stands--- could you have a little platform rather like the ship where you have a lead man, on one side or the other - for a look out ?

Even if we did if there is a ship under the bow it would not be seen.

H.M. Coroner: If it stood out a bit ?

I do not think it would be feasible.

H.M. Coroner: In other words, are we to take it that it is impossible to see if there is anything immediately in front of you and you do not think there is any solution ?

The only solution I can see which would apply to the conditions at the time would be to have a lead ..... with the man letting go the line to go forward.

H.M. Coroner: Going back to the actual tragedy you said the first time you knew was when

you got the cries of the passengers but do you recollect the seaman  
with you saying that there was this dinghy?

No, I don't.

H.M. Coroner: You were here when he told the court that he told you there was a dinghy  
going round the bow?

No, I have previously asked him to speak up because he has such a low  
voice.

H.M. Coroner: In your opinion - I am sure you will make suggestions anyway to your  
people at British Rail - the traffic was not exceptional in the harbour  
that day? One gentleman said that it was not until he waved the third  
time that you acknowledged him?

That was not myself. I have got to look ahead all the time. I still  
find it hard to believe that he waved three times. I have no recollection  
of it.

H.M. Coroner: The passenger witness said he was stood there for about ten minutes before  
you sailed and he saw this particular dinghy. Was there someone on your  
bridge who could see?

Once the ship is alongside there is nobody up there. There is no point.

By the Jury: What lapse of time would there be between your arrival and the departure  
of the ship?

It would be according to conditions or what you are doing. I do not keep  
a look out in Yarmouth. There is no point.

Cross examined: I think it would be right to say that the view from the bridge is obstructed  
even more if there were a lot of standing passengers?

Yes, quite a bit more.

In other words the lower limit of your line of vision is lowered by five or  
six feet?

Yes.

I think it is right to say that a Master of these ferries has to have a  
foreign going Master's certificate and also to take boats in and out of  
harbours you have to have a Pilot's Exemption Certificate and you have  
both of these?

Yes.

I do not propose going over all the evidence again. We have been into it pretty thoroughly together and, as I have explained this to you before, the Police have gone into the question of the Captain being inebriated and I hope you are satisfied that this is something that happened after the disaster and not before. As I have said before, I think it is quite clear from what we have heard this small dinghy had two very inexperienced people in it and had got out of control but in spite of the very helpful efforts of at least two other yachtsmen to help them it got out round the bows of the ship and you have seen that in that particular position it cannot be seen from the bridge. From the actual facts, that is what happened and it got round the bow of the ship without the Captain knowing the dinghy was there and the ferry got under way. It is very easy to be wise after the event. You are, no doubt, wondering why did the harbour-master not do a little bit more but, obviously, the penny did not drop with him that this boat was in ~~danger~~ <sup>difficulty</sup>. I can see no other reason but it is part of his duties to look out. We are not here to try anyone but we are here to try to find out the cause of death and how it came about. I should say, first of all, that I am sure that the Harbour Commissioners have considered this matter very carefully and will do their best to see that good watches are kept. It must be very, very difficult for them, particularly in the summer. The other thing that worries me is the fact that a dinghy can get into such a position without being seen. We have had evidence that signals were made to the Captain but I hope you will suggest to British Rail especially that they will go into this matter and see if some form of platform could be rigged. I had a look at the sister ship yesterday and I think it could be possible for someone to be on the lookout. I could go on but you have got the facts just as well as I have. You have to decide on your verdict. I think there can be no other verdict than one of Accidental Death. If one had acted so monstrously to consider manslaughter we may have to think again but I think you will probably think that Accidental Death would be appropriate. Do you want to ask any more questions? If you do not can you consider your verdict where you are or would you like to retire and talk it over.

(The Foreman of the Jury said they would like to retire and they retired

for 20 minutes).

Foreman of  
the Jury:

We are agreed in our Verdict. We feel that as the accident occurred very much through these two people being on an adventure the Verdict should be Misadventure. We further feel that in view of the total inadequate visibility available to the Captain and all ferry operators that a strong recommendation should be made that there should be two persons positioned in front of the ferry to keep a look out so as to give adequate notification to the bridge.

Solicitor:

If I may just say that the Chief Superintendents who run these ferries have both been <sup>present</sup> in court to-day and will have heard what the Jury have said and I shall be making a recommendation to the proper authority.

Solicitors

I think it would be improper if I left without passing to the father of this young boy the sincere regrets of Captain Cudlipp.

H.M. Coroner:

I shall, therefore, record a Verdict of Misadventure, namely that Alexander Thomson, aged 13 years, of "Haytor," The Ridgeway, Mill Hill, London, N.W.7. died in Yarmouth Harbour, Isle of Wight, on the 12th August, 1979 when the dinghy in which he had been rowing with a friend was struck by the British Far Ferry 'GENWOLF' the cause of death being Multiple Injuries.



# Notes of the Post-Mortem Examination of

(formerly John

Name of deceased \* THOMSON Alexander MELLOWS Sex Male Aged 13 years  
 Observers present at examination \* Mortuary Technician, Sgt. Auckland, Hampshire Police  
 Date and time of examination \* 11.45 a.m. 13th August, 1979.  
 Place where examination performed \* St. Mary's Hospital, Newport, Isle of Wight.  
 Estimated time of death \* .....

If a histological or bacteriological examination is to be made the pathologist will initial here:

**Chief points in the history of the case.**

The examination was made of parts of a body recovered from the sea after a collision between a sailing dinghy and a car ferry at Yarmouth harbour, when a 13 year old boy was lost from the dinghy. He wore a steel brace around his chest and neck, having suffered from myotonia congenita from birth.

**External Examination.**

Height \* (length). Weight

Apparent age \*

The parts of the body are consistent with a male child of 13 years.

Nourishment \*

Good.

Temperature in rectum

Not present.

Rigor mortis, \* hypostasis, decomposition

Evidence of violence, \* burns

The left lower leg has been severed from the left thigh at the knee. The upper part of the body has been severed from the trunk at the level of the epigastrium in front and the 9th or 10th thoracic vertebrae posteriorly. There is a bruise on the left buttock. There is a marked scoliosis of the lumbar spine convex to the right. A long-standing bursa is present over the right knee cap. Pubic hair is not present.

Identification \* (tattoo marks, \* old scars, \* special deformities)

Body surface -- pallor, abnormal coloration Normal.

Orifices of body, hair, teeth

**Internal Examination.**

*Cranial Cavity*

Skull, \* scalp and face

Only 2 small irregular pieces of scalp are present. The larger 6" x 2" has the top part of the right ear at one end and carries dark-brown hair. The other piece 4" x 2" also has dark-brown hair and appears to be from the neck hairline.

Brain \* -- weight, etc.

Not available.

Meninges \* and blood vessels

Not available.

Spinal column, cord and meninges

*Thoracic Cavity*

Not present.

Mouth, \* tongue, \* tonsils, oesophagus \*

Larynx, \* trachea, \* bronchi, thyroid and thymus glands

Not present.

Lungs, \* pleurae, \* diaphragm

Not present.

Pericardium \*

Not present.

Heart \* (size, weight, cavities and contents, valve orifices and valves), heart muscle and coronary arteries.

Not present.

Aorta, pulmonary and other blood vessels \*

[P.T.O.]

Internal injuries (thoracic)	The trunk has been severed by a blow from a fairly sharp edged instrument, such as a ship's propeller.
Abdominal Cavity	
Stomach and contents *	Normal.
Peritoneum, * intestines * and contents, appendix, mesenteric glands, * etc.	The small intestine is missing from the body, but the mesentery and small intestine were received separately and fit the space.
Liver * and gall bladder *	Normal.
Spleen *	Normal.
Kidneys * and ureters *	Normal.
Bladder * and urine *	Normal.
Suprarenals, pancreas	Normal.
Generative organs, * breasts, prostate, etc.	The generative organs are those of a 13 year old boy.
Internal injuries (abdominal)	There is some recent haemorrhage around both kidneys.
Are all other organs healthy? *	Yes.

Cause of death as shown by the examination *:	In my opinion the cause of death was:—										
	<table border="0"> <tr> <td style="text-align: center;">I</td> <td style="text-align: center;">I</td> </tr> <tr> <td>Disease or condition directly leading to death .. .. .</td> <td>(a) Multiple Injuries due to (or as a consequence of)</td> </tr> <tr> <td>Antecedent causes .. .. .</td> <td rowspan="2">(b) .. .. . due to (or as a consequence of)</td> </tr> <tr> <td>Morbid conditions, if any, giving rise to the above cause stating the underlying condition last .. .. .</td> </tr> <tr> <td style="text-align: center;">II</td> <td style="text-align: center;">II</td> </tr> <tr> <td>Other significant conditions, contributing to the death, but not related to the disease or condition causing it † ..</td> <td>(c) .. .. .</td> </tr> </table>	I	I	Disease or condition directly leading to death .. .. .	(a) Multiple Injuries due to (or as a consequence of)	Antecedent causes .. .. .	(b) .. .. . due to (or as a consequence of)	Morbid conditions, if any, giving rise to the above cause stating the underlying condition last .. .. .	II	II	Other significant conditions, contributing to the death, but not related to the disease or condition causing it † ..
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Any further remarks \*

Signature and qualifications \* *Robert MacAndrew, MB, ChB, FRCPath.* Date *Dr. R. MacAndrew*  
 Address \* *St. Mary's Hospital, Newport, Isle of Wight.* Date *13th August, 1979.*

† This does not mean the mode of dying, such as, e.g., heart failure, asphyxia, asthenia, etc., it means the disease, injury, or complication which caused death.  
 ‡ Conditions which do not in the pathologist's opinion contribute materially to the death should not be included under this heading.  
 These notes should be short and concise records of the facts observed; if opinions are expressed the grounds upon which they are based should also be stated. Scientific terms should be avoided when possible.

**AVERAGE WEIGHTS AND MEASUREMENTS IN ADULTS**

	MALE	FEMALE
Brain .. .. .	50 oz.	45 oz.
Heart .. .. .	10 to 12 oz.	9 to 11 oz.
Lungs { Right .. .. .	24 oz.	21 oz.
Left .. .. .	21 oz.	16 oz.
Liver .. .. .	48 to 58 oz.	40 to 50 oz.
Kidneys (together) ..	11 to 11½ oz.	10½ to 11 oz.
Spleen .. .. .	5 to 7 oz.	

	Valve Orifices	Circumference
Aortic .. .. .	Admits 2 finger tips	3 inches
Pulmonary .. .. .	2 fingers	3½ "
Mitral .. .. .	3 finger tips	4 "
Tricuspid .. .. .	3 fingers	4½ "

Newly-born Infant at full term		
Length .. .. .	18 to 20 inches	
Weight .. .. .	6½ to 8 lb.	

**DEATH BY POISON**

In cases where poison is suspected, the stomach and its contents, the liver, the kidneys, and any urine in the bladder, should be placed in clean stoppered glass jars for analysis. The jars should be sealed and labelled.

**POST-MORTEM EXAMINATION OF A NEWLY-BORN INFANT**

Note the weight and length, the length of the cord and whether cut, torn, or tied, the presence of a caput succedaneum, and of vernix caseosa on the surface of the body. Note the height of the diaphragm and the condition of the lungs, whether they contain inspired air or show interstitial emphysema or putrefactive gas formation, the degree of patency of the foramen ovale and ductus arteriosus. Examine the lower end of the femur and the upper end of the tibia for ossification centres in the epiphyses, and the os calcis, astragalus, and cuboid bones of the foot for centres of ossification.

**PRESERVATION OF TISSUES FOR MICROSCOPICAL EXAMINATION**

Pieces not more than ½" thick should be placed in a 10% solution of Formalin in normal saline (Formol Saline) or in Zenker's solution.

**PREVENTION OF INFECTION**

Rubber gloves free from holes should be worn, Surgeons' gloves are suitable, especially if they can be obtained with long arms.  
 After use they should be thoroughly washed and tested for holes, and are then sterilised by boiling or by placing in an antiseptic solution.  
 Recent wounds should be painted over with collodion before starting the examination. If the operator pricks, cuts or scratches himself during the autopsy he must stop at once, remove the glove and make the wound bleed by placing in hot water, sucking the wound, or by a tight ligature round the forearm; allow bleeding to continue for several minutes, immerse in tincture of iodine for five minutes, put on an antiseptic dressing and keep the part at rest for a time.

HAMPSHIRE CONSTABULARY  
REPORT OF SUDDEN DEATH

From: Officer-in-Charge,  
Police Station Yarmouth, I.W.

To: H.M. Coroner 36 Union Street,  
Ryde, Isle of Wight

1. Deceased Person: Name Address Place and Date of Birth Occupation Single/Married/Widowed/Divorced	Alexander THOMSON, 'Haytor', The Ridgeway, Mill Hill, London, NW.7 London - 7.2.1966 Schoolboy Single
2. If deceased is a: (a) Married woman or widow, state maiden name; (b) Widow, state late husband's full name and occupation; (c) Child, state father's name, occupation and address; (d) All married persons, give date of birth of surviving spouse	c) Maurice Livingstone THOMSON, Retired Medical Practitioner 'Haytor', The Ridgeway, Mill Hill, London, NW.7
3. Time, date, by whom and from whom report received	1738 hrs. 12.8.79 from Needles Coastguard to Newport Police Station
4. State where and when (day and hour) the deceased died or was found dying or dead	Yarmouth Harbour 1715 hrs. 12.8.79
5. Present location of body	St. Mary's Hospital Mortuary
6. Persons present at death (full particulars)	Linda POWELL, 28 yrs. of 27 Shireshall Lane, Hendon
7. By whom body found (full particulars)	Mr. Raymond Kenneth HILTON, 2 Upper Golflinks Road, Broadstone, Dorset.
8. Apparent injuries	Body mutilated
9. By whom, when and where last seen alive (full particulars)	Linda POWELL in rowing dinghy in Yarmouth Harbour
10. Particulars of any illness before death including insensibility	Myotonia Congenita with fragility of the skin; Hyperextensionability. Congenital defect.
11. Particulars of doctor who attended: (a) before death - state when and for what period (b) at death (c) after death	c) Dr. HURLEY, 'Landguard', St. James' Street, Yarmouth
12. Name of undertaker removing body and time and date of removal	Removed by ambulance
13. Name/Address of undertaker finally disposing of body	Unknown at present
14. Whether cremation or burial	Unknown at present

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REPORT OF INVESTIGATING OFFICER

(including details of circumstances leading up to, at,  
and after death)

Sir,

Alexander THOMSON was born on 7.2.66 in London as John MELLOWS of Irish extraction. He was abandoned at birth, and was raised in St. Margarets Childrens Home in London. In 1974, when he was 8 years old, he was adopted by Mr. and Mrs. THOMSON and renamed Alexander THOMSON. Since then he has lived with Mr. and Mrs. THOMSON as their son, along with six other children.

Alexander was physically handicapped, suffering from Myotonia Congenita with a fragility of the skin. He also had hyperextensionability and a congenital defect which resulted in a multiple deformity. Earlier in life he suffered from asthmatic attacks. Alexander wore a 'Milwaulkee' brace to prevent scoliosis, which enclosed his chest from the waist upwards and supported the head in an upright position. It was made of metal with pads and strapped at the back and restricted his movements to a certain degree. Before June, 1979, Alexander wore leg clamps, but after an operation on his foot he started to use crutches discarding these before coming on holiday in August. He visited a clinic twice a year for treatment.

He attended a normal school and learned to swim, being a competent swimmer. Alexander was able to cope with normal school lessons, but was considered to have slow mental reactions.

Alexander came to the Isle of Wight with his family on the 26th July.

On Sunday, 12th August, 1979, Alexander went with his family to Yarmouth Harbour to watch the boat regatta. This was an event involving small dinghies, mainly for fun. Alexander started the afternoon by using a rubber dinghy owned by his parents. He then got into a small wooden dinghy with a friend of the family, Linda POWELL (28 yrs.) He started off by rowing around, but soon got tired and let Linda continue the rowing. She was sat in the stern, he amidships. They were then caught in the ebb tide taking them to the mouth of the harbour and near to the Solent facing the end of the Yarmouth/Lymington car ferry which was tied up. Attempts were made by passing boats to pull them clear.

As far as can be ascertained, they were swept into the path of the ferry by a combination of the tide and suction around the moving ferry. This was at about 1715 hrs. 12.8.79

The girl, Linda, survived, but Alexander died and his mutilated body recovered a few minutes later. The boy, Alexander, was pronounced dead by Dr. HURLEY at 1810 hours on 12.8.79.

Date 13th August, 1979

(Signed) *P. Corke* P.C.1365 (full name)  
(Investigating Officer)

Forwarded to H.M. Coroner

Date 13 - 8 - 79

(Signed) *N. Auldham* PS 35  
(Officer-in-Charge)

RESULT OF ENQUIRY

Place and date of Inquest \_\_\_\_\_

Name of Coroner \_\_\_\_\_

Verdict \_\_\_\_\_

LT 18/8/79

## Disabled boy killed in ferry accident

**T**RAGEDY struck a family of holidaymakers on Sunday when a 13 year old disabled boy was killed after a collision between a dinghy and the Sealink ferry Cenwulf at Yarmouth.

The following day, Capt. Leonard Wheeler, Sealink's Portsmouth manager, was reported as saying that there were near misses every day and collisions were almost inevitable.

Asked to explain this comment, a spokesman for Sealink told the "A. & T." on Tuesday, "The Solent is a very congested waterway with a great deal of craft, both amateur and professional, and the ferry captain's job is a very difficult one at this particular time of year. It takes a great deal of skill to avoid a collision at times, especially when the amateur makes a move straight in the path of the ferry."

An inquest into the death of 13 years old Alex Thomson was opened and adjourned on Tuesday afternoon at Newport Guildhall, when it was stated that death was due to multiple injuries. The boy's father, Dr. Maurice Thomson, who had been staying with his wife and son in their holiday chalet in Freshwater, said the boy had congenital bone abnormalities. Eight weeks previously he had undergone an operation to his left leg. The Coroner's court will resume on September 28th.

British Rail have instigated an internal enquiry to establish what happened, but the results may not be made public. It is understood that the Department of Trade and Industry are also investigating the incident.

The boy had been taken for a row around the crowded Yarmouth harbour on Sunday afternoon by family friend, Miss Linda Powell, of Hendon, Middlesex, in an 8-foot clinker dinghy. Both were sucked under the Cenwulf as it left for Lynnington packed with holidaymakers. Miss Powell was thrown clear after passing under the hull, but Alex was killed by the propellers.

Apparently, no one on board was aware of the accident, and the ferry was halfway across the Solent before Captain Gordon Cudlipp received a radio message.

The Cenwulf is powered by two Voigt Schneider propellers — one on each diagonal corner. These are in the form of a rotating disc through which

protrude four blades. As the disc rotates, the blades take up continuously altering angular positions which can be controlled to take the boat in any direction. This gives a high degree of manoeuvrability, but presents a hazard considerably greater than a single conventional propeller.

# Inquest opened on dinghy boy in harbour tragedy

**A 13-YEAR-OLD London boy, holidaying at Brambles Chine, Freshwater, was killed in a collision involving the Sealink ferry Cenwulf at the entrance to Yarmouth Harbour on Sunday afternoon.**

Chief Inspector E. T. H. Hoar told the County Press that the boy, Alexander Thomson, of Mill Hill, North London, was in a wooden dinghy with 28-year-old Mrs. Linda Powell, a family friend, also of Mill Hill, when they encountered difficulties owing to tidal conditions at the harbour entrance.

"The woman and the boy were apparently seeking assistance from other pleasure craft and a line was passed to their dinghy, which failed to hold," said the Chief Inspector.

"The woman jumped into the water and surfaced clear of the Cenwulf, but it is believed the dinghy went under the bows."

The accident happened at about 5.15 pm.

## SMASHED

Chief Inspector Hoar said Alexander, who was physically disabled, had apparently come into contact with the ship's propeller. The dinghy was smashed to pieces and Alexander would have died instantly, he said.

The ferry's master, Captain Gordon Cudlipp, 47, was reported to have been so shocked by the incident that he asked to be temporarily relieved of command.

Police were trying to trace two, and possibly three, occupants of a red inflatable dinghy who apparently tried to tow the dinghy carrying Alexander and Mrs. Powell away from the area of the Cenwulf, but apparently lost the rope immediately before the accident.

An inquest on the boy was opened in Newport on Tuesday, and adjourned until September 28 after Mr. J. V. Bullin, Island coroner, had been given evidence of identification.

Dr. Maurice Livingstone Thomson, of The Ridgway, Mill Hill, London NW7, said his son had distortion of the ribs and spine, and had eight weeks earlier had an operation on his left leg to improve the function of the ankle bones which had been abnormal from birth.

Dr. Robert MacAndrew, consultant pathologist for the Island, said that death was due to multiple injuries.

*Isle of Wight County Press*

*18 August*

*1979*