HM CORONER
Falkland Islands

INQUEST TOUCHING UPON THE DEATH OF EILEEN LARRIMORE

VERDICT, FINDINGS AND REASONS

On 3rd January 2012 the Clipper Adventurer (now renamed the Sea Adventurer) was in South Georgia waters on a cruise of the South Atlantic region. As part of that cruise experience some of the passengers on board had chosen to go ashore (I shall refer to them as the "the walking party") in order to carry out what had been presented as part of the Shackleton Walk, that is the last part of the now legendary rescue mission undertaken by Ernest Shackleton in 1916 when he set out to find help for the crew of his ship, Endurance, after they had become stranded on Elephant Island. The walk was to go between Fortuna Bay and Stromness.

Amongst the passengers who had decided to go on that walk were Mrs Eileen Larrimore and her husband, Mr Randall Larrimore.

The walking party reached the highest part of the walk and then began the descent into Stromness where the ship was waiting to pick them up.

It was during that descent that a tragic incident occurred which resulted in the death of Mrs Eileen Larrimore.

It has been the duty of this Inquest to enquire into the details of the death of Mrs Larrimore, to formally confirm that it was Mrs Larrimore who lost her life, and to answer the questions as to when, where, and how she died.

Although the incident occurred in South Georgia, jurisdiction in this matter has been assumed by me as HM Coroner of the Falkland Islands and this Inquest has been carried out under the provisions of Falkland Islands Law.

Inquests are usually the only forum where events that led to a death are subject to public scrutiny. The duty of the Coroner is, as Lord Bingham (then Master of the Rolls) said in the case of Jamieson, *"to ensure that the relevant facts are fully, fairly and fearlessly investigated".* However, I repeat what I have said earlier; that whilst it is the task of this Inquest to ascertain the facts and expose them to public scrutiny, it is not the task to conduct a trial of any person or persons or to judge as to liability or blame.

It is also my duty to complete what is called the Inquisition in which the answers to the questions asked are recorded. In expressing what is known as my verdict I am of course mindful of the terms of Rule 39 of the Falkland Islands Coroner's Rules in which it states:

> *"No verdict shall be framed in such a way as to appear to determine any question of -*
>
> *(a) criminal liability on the part of a named person; or*
>
> *(b) civil liability."*

Having said that, it is important to make clear to all that the outcome of this Inquest does not affect the rights in any way of any person to take such actions as they may consider appropriate in any other legal proceedings.

In this Inquest the interests of Zegrahm Expeditions, who ran the expedition and, it seems, sub-chartered the Clipper Adventurer from Quark Expeditions, were represented by Mr Forlin

The Law Courts, Town Hall, Stanley, Falkland Islands, FIQQ 1ZZ
Telephone: 00500 27271
Email: cgumsley@townhall.gov.fk

QC, and the interests of the South Georgia Government by the Attorney General. Mr Larrimore, Mrs Larrimore's husband, was also an interested person within the meaning of the Act and Rules, and gave evidence, but did not attend the Inquest in person and has chosen, as is his right, not to be represented.

I have heard evidence from a number of people, mainly through Skype or telephone communications. In the circumstances of the very specific conditions of the Falkland Islands I consider that taking evidence in this way has been the best way to ensure that justice is done, that as much information as possible has been given to this Inquest, and that as thorough an investigation as possible has taken place.

The witnesses from whom I have heard via Skype or telephone are:

- Randall Larrimore
- Jillian Harvey
- Dr John Smeaton
- Karen Hale
- Martin Collins
- Brent Stephenson
- Jeffrey Dujardin
- Michael Moore
- Robert Geoffrey Renner
- John Kristensen
- Captain Kenth Grankvist
- Peter Harrison
- Alex McNeil

I have received evidence from the following witnesses in Court:

- PS McDade
- Richard McKee
- William Lawler, the pathologist
- DI Street

I have also admitted into evidence the following documents and documentary exhibits in accordance with Rule 33 of the Falkland Islands Coroner's Rules:

- Parts of a report by Dr Peter Goode – Accident and Emergency and Trauma Medicine Expert dated 9th January 2013
- Statements and exhibited reports and/or interviews of:
  Nathan Kristensen
  Sonia Surguy
  Keiron Fraser (Report)
  Dion Hobcroft
  Mario Sande
  Melanie Craft (extracts from her interview)
  Lisa Martin
- New Expedition Leader Briefing notes
- Copy of Information for Visitors 2011
- Visit Application Form by Zegrahm
- IMO guidelines submitted as contingency plans with list of specific safety on board
- Visit Permit Holder Landing Declaration
- Permit granted to Zegrahm
- Additional information for Visit Permit Holders
- Copy of Visitor Management plan published 2008
- Copy of Visitor Management plan published 2012
- Sub-charter contract between Zegrahm and Quark

- Booking terms and conditions from Zegrahm website
- Initial Medical Evaluation Report Addendum
- Declaration of Death
- Report of Dr Lawler
- Sub-Charter agreement between Zegrahm and Supernova Expeditions
- Report of Martin Collins in relation to a walk carried out on 25th January 2012 and Report of Shackleton Walk route taken on 25th January 2013

The following exhibits to which I have had reference are:

- Hiking Boots
- Rubber overboots
- Maps of:
  Busen Peninsula
  Thatcher Peninsula
  Island of South Georgia
- Image of Route of the Shackleton Walk plotted by Dr Fox
- The "Dr Collins" stills of the fly by area (produced by Dr Fox)
- The "Mr McKee" improved quality stills of the fly by area (produced by Dr Fox)
- A representation of a fly by from Stromness to Fortuna
- A representation of a fly by from Fortuna to Stromness
- The following sets of photographs:
  1) The "Kristensen" Photographs taken by Dr Kristensen on the day of the incident
  2) The "McNeil" photographs contained in the report of Alex McNeil from the day of the incident
  3) The "Hobcraft" photographs taken by Dion Hobcraft
  4) 3 Photographs taken on the day by Randall Larrimore
  5) The "Governor/Collins" photographs taken on 18th January 2013
  6) The "Dr Salcedo" photographs taken on the day
  7) The photographs and videos taken by Mr Barton on his visit to South Georgia

In respect of the evidence that has been received by this Court I think it is important to make the following observations:

- The Dr Fox photographs which contain GPS plots include waypoints provided by Richard Price in his statement and report (and which have become known as the blue dots) have not been taken into consideration by me, as Richard Price has not given evidence in the case and I did not consider it appropriate to read his statement and report into evidence.
- I have also watched a video provided by Mr Barton, the expert instructed by Zegrahm, who attended South Georgia to study the incident location and surrounds. It is now clear that Mr Barton was in the wrong place and I consequently disregard that video, and the photographs in a report that was disclosed, in their entirety.

I have therefore heard and read a considerable amount of evidence. I have reviewed all this evidence and I have had all this evidence in mind when considering my verdict.

I have considered the following possible verdicts in this case:

The short form verdicts of:

- Accident/Misadventure and,
- Unlawful Killing by reason of gross negligence manslaughter, either by an individual or by a corporate entity.

I was also invited to consider whether an open verdict might be appropriate.

Firstly, in respect of an open verdict, I have heard a considerable amount of evidence and I am satisfied that this has been sufficient for me to come to proper conclusions as to the questions I must answer and specifically to record how Mrs Larrimore came to her death.

Secondly, in relation to the verdict of unlawful killing, I have considered the principles as stated in the case of *Adamako* which state that in order for there to be gross negligence manslaughter it must be proven to the criminal standard that:

1) There was a duty of care owed to Mrs Larrimore.
2) There was breach of that duty of care.
3) The breach caused the death.
4) That the breach should be categorised as gross negligence and therefore a crime. That is that the behaviour was such that it should be judged as having been criminal.

In addition, for there to be corporate manslaughter, as the English Corporate Manslaughter Act 2007 is not law in the Falklands, the pre Act position must be considered. In order to establish manslaughter in these circumstances it would be necessary to prove that the relevant breach was committed by a directing mind of the corporate body involved.

Whilst I may be satisfied in relation to some of the above elements, in order to find a verdict of this nature I must be sure of all the above elements.

Unlawful Killing is an unusual verdict and requires a very high standard of proof. I do not consider that, on the evidence I have heard, such a situation arises here and I do not consider such a verdict appropriate.

I have then considered whether the verdict of Accidental Death would be an appropriate verdict, but I do not consider that it properly deals with the complexities of this case.

It therefore seems to me that a Narrative Verdict is appropriate in this Inquest because the circumstances of the death cannot be adequately or properly reflected in a short form verdict.

In considering how this might most appropriately be expressed, and during my deliberations of all I have read and heard in this Inquest, I have come to a number of conclusions as to the evidence and the facts in this case and I will now set out those findings. In doing so I have not sought to decide every point in issue, but have concentrated on those which I consider to be relevant and pertinent to the verdict to which I have come.

In coming to the conclusions that I have in respect of the evidence:

1) I am, of course, mindful that the events that led to Mrs Larrimore's death took place over a year ago and the affect this may have had on memories and recollections of that day, although it is right to say many of the witnesses did provide statements and reports of the incident very shortly after it had occurred.
2) I also have very much in mind the emotional affect that this incident has had on some, if not many, of the witnesses.

Before I set out the findings I have made it is appropriate that I should address the following issue:

The involvement of Peter Harrison

During this Inquest I have heard allegations made by witnesses, in particular Dr Smeaton and Dr Kristensen. These allegations include that, in the days following the death of Mrs Larrimore, Peter Harrison did not deal with the fact of a death on the cruise with the gravity it deserved, that he made comments which displayed poor taste, and that he made suggestions that he had influence in important places and with powerful people, that he said that he had offered inducements to Police Officers to speed them in their investigation, and that I, as Coroner, was merely trying to make something out of Mrs Larrimore's death in order to give me something to do.

Dr Smeaton described this as a “snow job”, and Dr Kristensen was so concerned that he wrote to DI Street to inform him of what he said had happened at a speech given by Mr Harrison as the Clipper Adventurer left Stanley, and to express concern that Mr Harrison might be able to exert influence over this Inquest.

Mr Harrison said in evidence that these allegations had upset him. He said that he had been hurt and bewildered by them. He suggested that Dr Kristensen had taken information from various sources and had totally misrepresented it in order to carry out a character assassination, and that Dr Smeaton was part of a group who could “not be pleased” and “gave off bad Karma.”

In evidence Mr Harrison said that after the ship had brought Mrs Larrimore’s body to the Falkland Islands, Police Officers of the RFIP had suggested that the ship might be able to leave Stanley sooner if they remained on board to take evidence and their girlfriends and wives be allowed to accompany them on what would amount to the remainder of the cruise.

DI Street has given evidence that he recollected that there were various suggestions put to him by Mr Harrison, as the RFIP worked throughout the evening and night to try and assist with the ship being able to leave, but that any suggestion of that kind had come from Mr Harrison and certainly not from him or any of his officers.

I considered that this evidence was of relevance, because of its nature, for the sake of transparency in these proceedings, to ensure that in this public hearing such matters were properly aired and because I considered that these matters may go directly relevant to the issue of the credibility of the witnesses involved in these suggestions and counter suggestions. I was also concerned to consider whether, in the light of the allegations made, any form of undue influence had, or might have been, exerted over Zegrahm staff or indeed anyone in relation to the evidence that they gave.

Mr Harrison seems, in my judgment, to be a man somewhat obsessed with Zegrahm and clearly not able to let go of the business that he helped to start. Despite apparently relinquishing his legal status in the company in 2009, despite apparently having no financial interest, despite portraying himself as just “the bird man” to this Court, he clearly continues to consider himself an important man in the organisation. In coming to that conclusion I have in mind his constant use of the term “we” in giving evidence almost in the manner of a corporate spokesperson, Jill Harvey saying he portrayed himself as more than a visiting lecturer and her comment that he liked to take a control role on the ship, Captain Grankvist stating that he thought Mr Harrison had some influence as a former owner, and Mr Harrison himself describing himself in the email sent to me as the senior Zegrahm representative on the Clipper Adventurer. I am also satisfied that Zegrahm must have been aware of the way that Mr Harrison was portraying himself and did little, if indeed anything at all, to keep Mr Harrison in check and to clarify his true position as regards the company.

I find the suggestion that a professional man like Dr Kristensen would have bothered to take and search around for snippets of information about Mr Harrison, and then to carry out what would amount to be a somewhat convoluted character assassination by taking the time to write to the Coroner’s Officer with fabricated or manipulated evidence, and then repeating it before this Inquest, to be unlikely in the extreme. I found Dr Kristensen to be a credible and helpful witness. I also find it difficult to accept that Dr Smeaton would also create or misrepresent Mr Harrison’s behaviour for no apparent or credible reason.

I am entirely satisfied that comments where Mr Harrison suggested he had influence in powerful places were made. I am satisfied he made comments which were derogatory to me and the office of Coroner, although this Court has broad shoulders and pushes such matters aside. I am also satisfied that his attitude following Mrs Larrimore’s death was inappropriate and offensive to a number of passengers. I prefer the evidence of Dr Smeaton and Dr Kristensen in this regard. I also accept the evidence of DI Street that he made no inappropriate suggestions to Mr Harrison.

Mr Harrison's behaviour may have been down to his desire to complete what he saw as a great adventure, and I note the somewhat poetical phraseology he used in his evidence when speaking about proceeding with the trip, notwithstanding the death of Mrs Larrimore. His behaviour may have been meant as some kind of joke; its intention may indeed have been to somehow lift spirits. Nevertheless, I am satisfied that words of the nature and tone alleged were said. I am also satisfied that he did exert influence on this trip due to the perception (which was not clarified or corrected by Zegrahm) that he was a man of power within the company.

However, I am also satisfied that the majority, if not all, of the other staff on the cruise showed proper deference to the situation and displayed professionalism and compassion in the aftermath of the incident. These qualities were expressed by
Mr Larrimore and other witnesses who spoke of the respect that Mr Larrimore was shown, by Dr Smeaton who contrasted Mr Harrison's behaviour with that of Jill Harvey and the others who, as he said, represented Zegrahm very well, and Dr Kristensen who said that most of the staff had dealt with the aftermath appropriately.

I also make it clear that, having considered the behaviour of Mr Harrison, as I have found it to be, I am satisfied that, despite his position in this company, real or perceived, which I consider is still one of substantial influence, and his domineering personality, the evidence given to this Inquest by those employed or engaged by Zegrahm, has not been affected by any of this influence.

Consequently, save for the matter of Mr Harrison's credibility, which I have in mind when considering his evidence as to the events of the day of the incident, I make it clear that I put my conclusions as to Mr Harrison's behaviour out of my mind in considering the specific questions that I have to answer in this Inquest.

Conclusions and findings

I turn then to the conclusions I have come to in respect of the evidence which I have found on the balance of probabilities, that is that they are more likely than not:

South Georgia

1) South Georgia is a British Overseas Territory in the South Atlantic, a visually stunning place, almost alpine in appearance in some areas and is a haven for wildlife.
2) It is one of the more remote and, at times, inhospitable places in the world, approximately 750 miles from the Falkland Islands and about 1100 miles from the South American continent.
3) There is no permanent population of any great number on the Islands, those residing there being a small number of government officials and scientists.
4) There is no airport. There may be times when helicopters are on the Island for specific projects, or when a military ship is visiting, but this is not a common occurrence.
5) There are no search and rescue facilities.
6) Medical facilities are limited and generally reserved for those working on the Islands and those working in the fishing industry.

Tourism and the permit application

7) In recent years tourism has increased with up to approximately 70 cruise ships visiting annually, with the passengers hoping to experience the remoteness and to see the landscape, the historical areas and the wildlife that the Islands contain.
8) In order to be able to go ashore it is necessary to obtain a permit from the South Georgia Government. An application must be completed by the operators or owners of all commercial and private vessels.
9) Such an application dated 7th June 2011 was submitted by Zegrahm.
10) The application form also requires that "All visit applicants must study carefully the current "Information for Visitors to South Georgia" booklet" and that "Submission of an

application is taken to mean that the applicant has read and understood the provisions in that booklet and agrees to abide by them".

11) The Expedition Leader, as stated in the application, was to be Russell Evans.
12) A permit was granted in response to the application made by Zegrahm on 25th July 2011. The permit holder was stated to be Russell Evans. This was later changed by Zegrahm to be Jill Harvey. This change was communicated and accepted by the South Georgia Government through email correspondence. Jill Harvey therefore became the Expedition Leader.
13) Any Expedition Leader must be approved. In order to be approved as an Expedition Leader they must attend King Edward Point and be fully briefed by one of the Government Officers. Once a person is approved, and that approval is current, they are permitted to land at approved visitor sites without first attending King Edward Point. However, they are expected to visit King Edward Point at some point during the visit to receive a shorter briefing as to any changes.
14) Within the Terms and Conditions of the permit it states that the permit holder must be familiar with, and comply with, the procedures set out in the "Information for Visitors to South Georgia 2011 booklet", the "Visitor Management Policy" and the "Site specific visitor management plans and codes of conduct". They also state that "all landings must be made in compliance with procedures set out in the Information for Visitors to South Georgia booklet".
15) The "Information for Visitors to South Georgia" booklet states, inter alia, that "All approved landing sites Codes of Conduct and existing Site Visitor Management Plans must be adhered to".
16) I am satisfied that the South Georgia Government made it clear and emphasised to Zegrahm and all others who applied for permits that the Visitor Management Plan terms and conditions were to be complied with.

The Visitor Management Plan

17) The Visitor Management Plan for the Shackleton Walk in force in 2011/12 was created in 2008 (I shall refer to this as "the 2008 Plan").
18) On page 4 of the 2008 Plan under the heading "Guided Walking Areas" it states that: "The specified route should be followed (see below) to avoid creation of multiple tracks, potential disturbance of wildlife and damage to sensitive vegetation communities".
    There is no reference in this section to any other potential consequences of not following the route. In my view the use of the word "should" allows for a degree of discretion in what route to follow.
19) In addition, on page 3, under the heading "Visitors" it states that:
    "It is strongly advisable that the hike be led by someone with previous experience of the route using the waypoints provided".
    The Plan thereafter sets out in some detail a description of the route to be followed by reference to waypoints (I shall refer to this as the "official route") and listed the relevant GPS co-ordinates of these waypoints.
    I find that the phraseology of this to be ambiguous. In my view it might be interpreted to read that the term "strongly advisable" relates to both the hike being led by someone with experience and to it being carried out using the waypoints provided.
20) I am therefore satisfied that, as a consequence, the requirement to follow the official route could easily have been perceived, by reading the 2008 Plan, to have been an advisory one rather than a mandatory one.
21) I also note that in the 2012 version of the Visitor Management Plan the wording has now been changed to read:
    "It is important that the specified route and waypoints provided are followed" and that "the hike should be led from the front by two expedition staff members with a good knowledge of the route using the waypoints provided" and reference is made to following the correct waypoints which should be checked in advance with the Government Officers at King Edward Point. I consider that this is clearly an acknowledgement that clarity was needed in the wording of the Plan.
22) I should also say at this point that the 2008 Plan was missing a longitude reading in respect of one of the waypoints. However, the incident took place some distance

from this and there were a number of waypoints after this one, and before, where the incident took place. I am therefore satisfied that this missing longitude reading played no part in the occurrence of the incident.

The walking party and the briefings

23) Jill Harvey was fully aware of the Terms and Conditions that surrounded the landings on South Georgia in general and the Shackleton Walk in particular.
24) On 3rd January 2012 the walking party of approximately 32 passengers, 4 members of staff assigned specifically to the hike and approximately 4 other members of staff set off on the Shackleton Walk.
25) There had been two briefings given to passengers in the days leading up to the Shackleton Walk. Rick Price was to lead the walking party.
26) The Visit Permit Application Holder Landing Declaration states that "It is up to the Permit holder to ensure that all individuals are informed about potential dangers and risks so as to enable the individual to assess and communicate any concerns they may reasonably have to the Permit Holder and/or the ship's staff".
27) Jill Harvey headed those briefings and when providing those briefings I am satisfied that she was working on the assumption that the official route would be followed and that the briefings given fairly portrayed the route as it would have been had that route been followed.
28) The official walk had been created to limit environmental damage and to provide a route that could be done in all conditions. The official route did not contain any substantial cliff areas or significant drops near to it.
29) I am also satisfied that Jill Harvey believed that, when she spoke to Rick Price, in a staff briefing, he would be following the route set out in the Visitor Management Plan. She asked him whether he was aware of the route, provided him with a copy of the Visitor Management Plan, and asked him if he had the co-ordinates loaded into his GPS. I am satisfied that he assured her that he had and that she was satisfied with this assurance.
30) As a consequence, no specific warnings were given in any of the briefings given to the passengers that there would be cliffs or drops near to the route and no indication was given to passengers at the briefing that the route which would be followed would not be the official one.
31) Although I am satisfied that Jill Harvey believed that the route that would be followed would be the one in the 2008 Plan I am not satisfied that she specifically set this out in terms as a specific instruction. I find it in inherently unlikely that she would have such a specific conversation with Mr Price who, on the evidence, was a very experienced guide.

The incident

32) At approximately 12.30pm the walking party had reached the highest point on the walk and were beginning to descend towards Stromness on a ridge largely composed of scree.
33) There was a path of sorts apparent on the scree and the walking party were travelling along this. The path continued down the ridge and then turned left in a dog leg fashion towards a stream. After the left turn the angle of the descent became significantly greater. Members of staff were stationed at the stream and were assisting members of the walking party across it.
34) At a point just above or around the dog leg Mrs Larrimore lost her footing, tripped, lost her balance and fell over. Mrs Larrimore then began to tumble, and then slide forwards building up speed. She was unable to stop herself and Mr Larrimore, who was in front of her, became aware of what was happening and grabbed out to try and stop her. He too was carried along by the momentum. I have heard evidence from Mr Dujardin that Mr Larrimore was sitting down, perhaps resting, slightly off the path. I am not satisfied that this was the case. In any event, even if this was right, this did not contribute to the fall in any way.
35) Jeff Dujardin, who was following Mrs Larrimore, tried to grab both Mr and Mrs Larrimore but was unable to do so.

36) Both Mr and Mrs Larrimore went forward past the dog leg left turn in the path and fell over the cliff into a ravine.
37) I am satisfied that Mrs Larrimore was merely walking down the path in an entirely appropriate manner. The angle of descent on the ridge was relatively shallow. At the point just prior to the incident the descent was becoming steeper but remained manageable.
38) The top of the cliff was only a few feet from the path that was being followed.
39) The existence of a cliff and certainly the extent of the drop were not particularly obvious to those walking down the ridge.
40) The location of the incident was not on the official route. It was on the opposite side of a steep ravine some distance from the official route.
41) At the time of the incident the official route had not been followed by the walking party for some time and distance. It is not entirely clear as to where exactly the walking party had deviated from the official route but I am satisfied, primarily by the evidence of Dr Collins, that it must have been some way prior to where the incident occurred.
42) It is not entirely clear as to why the official route was not followed. Whilst it is recognised that there may need to be deviations if weather, route conditions or snow dictates it there were no such factors apparent on that day.
43) Whilst it is not clear as to why the official route was not followed on this day I am satisfied that deviation from the official route had taken place on a number of previous occasions by Zegrahm, where routes which had been evolved from previous visits (some of which had taken place prior to 2008) were followed. The route followed on this occasion was the same route that had been followed on a similar walk on 27th October 2011. I am also satisfied that the route to be followed was usually left by Zegrahm to the choice and discretion of the walking party leader.
44) I note that the legend of Shackleton was that he climbed down a waterfall now called after him. The route where the incident took place went closer to the waterfall itself that the official route would have done.
45) There was a lack of knowledge and understanding within Zegrahm employees and/or contractors or those acting as their servants or agents as to whether there was a set route and if so what it was. I am also satisfied that, in general, no specific instructions were given by Zegrahm as to the route set out in the Visitor Management Plan or any requirement or advice to follow it.
46) No warnings were given during the walk that the route being followed was not the official one. No warnings were given during the walk that the route being followed would go near to a cliff. No member of staff was present in the area of the incident warning of the existence of the cliff and the need to take particular care.

Footwear

47) At the time of the incident Mrs Larrimore and Mr Larrimore were wearing rubber overboots. They had been advised that these would be appropriate if they were a good fit. Prior to the incident neither Mr Larrimore nor Mrs Larrimore had had any difficulty as a result of the footwear that they had on.
48) I am therefore satisfied that the type of footwear being worn played no part in the occurrence of the incident.

Medical treatment

49) Following the incident Mrs Larrimore was attended by Brent Stephenson who remained with her thereafter.
50) Mrs Larrimore was moved, by Brent Stephensen, before any medical attention arrived. This was to try to extricate Mrs Larrimore's face from the stream where she was lying face down. Dr Kristensen, a passenger with considerable medical trauma experience, attended to try to help and was able to support Mrs Larrimore's back.
51) Mrs Larrimore was initially conscious and responding to questions.
52) Although the fall and injuries were regarded as serious the true extent and nature of them was not initially appreciated.

53) The ship's doctor attended shortly afterwards. He had a medical backpack with him. It is not possible to say what equipment was contained in the medical backpack. Attempts to contact the ship's doctor have been unsuccessful.
54) The medical attention thereafter shown to Mrs Larrimore did not meet that set out in the universally defined and recognised ABCDE method for dealing with trauma.
55) In particular, there was no attempt to stop the bleeding from Mrs Larrimore's scalp, there was no thorough examination of her chest and there was a lack of simple monitoring carried out. The doctor did not take Mrs Larrimore's blood pressure, her pulse was not taken frequently and there was only one attempt at cannulating a vein.
56) The ship's doctor did not accompany Mrs Larrimore for much of the journey from the incident site to the place where she died and was not regularly evaluating her condition.
57) When the ship's doctor declared that Mrs Larrimore had passed away no action was taken to try and resuscitate her.
58) The South Georgia Government make it clear to cruise ships and other visitors that they are expected to ensure that they are medically self-sufficient. The notes attached to the application form submitted by Zegrahm for a permit clearly state that there are no medical facilities for visitors and that in an emergency, although there is a possibility of accessing the support offered to visiting fishing vessels at King Edward Point, this is not available elsewhere on the Island. The notes go on to state that there is no search and rescue or other emergency service on the Islands and that there is no independent transport from South Georgia to the Falkland Islands.
59) In their application, Zegrahm certified that self-sufficiency and contingency plans had been attached. The application form itself states that these should include management of medical evacuations, Search and Rescue contingency plans and plans for the repatriation of passengers and crew from within the SGMZ.
60) The plans attached to the application by Zegrahm were not specific plans developed by them and were not specific to this expedition but were generic guidelines from the International Maritime Organisation.
61) Although there was a plan amongst the staff and the crew as to how to deal with the practical issues surrounding an incident of this nature, namely as to how to provide a stretcher when required, there were no protocols in force to deal with specific medical emergencies such as how to deal with patients following a trauma situation, notwithstanding the remote location where the ship travelled to.
62) The medical clinic on the ship had basic and simple facilities and basic medical supplies. It is not clear as to what this amounted to but I am satisfied that the ship's doctor was unhappy about the medical supplies that he had been provided with. Although the passengers had been told that they would have an English speaking doctor on board, and that the doctor's conversational English may have been satisfactory, the doctor's English was not of a high standard. This is readily apparent from the written documents that he signed, the Initial Medical Evaluation Report and the Declaration of Death.
63) Following a request for assistance, the South Georgia Government Officers and medical staff did not hesitate to offer it and mobilised quickly. However, they were unable to reach the scene before Mrs Larrimore died.
64) Notwithstanding the above I conclude that, primarily on the evidence of Dr Lawler and Dr Goode, that such was the nature and extent of the injuries that Mrs Larrimore had sustained it would have been highly unlikely, given the location and circumstances of where the incident occurred, that she would have survived, even if the treatment given to her had been more proactive or any different.
65) I am therefore satisfied that any actions or omissions in the treatment that Mrs Larrimore received or in the equipment and facilities that were available did not cause or contribute to her death.

Medical cause of death

66) Mrs Larrimore died at approximately 2:21pm on 3rd January 2012.
67) There are no specific co-ordinates of the location where Mrs Larrimore died; I therefore record that she died on the route of the Shackleton Walk on the descent into Stromness harbour, in the British Overseas Territory of South Georgia.

68) I have heard from Dr Lawler who came to the Falkland Islands to give evidence. He carried out a post mortem examination on 13th January 2012 at the King Edward Memorial Hospital in Stanley. He concluded that, in his view, Mrs Larrimore had died from a combination of hypovolaemia and chest wall injuries, that is blood loss and breathing problems arising from the injuries she sustained in the fall.
69) Dr Lawler repeated that view in evidence. He considered that the medical cause of death should be recorded as 1a Multiple Injuries. I accept and confirm this.

The narrative verdict which I shall record is therefore as follows:

Particulars required by the Registration Ordinance
Mrs Eileen Madden Larrimore was born on 9th April 1948 in Pennsylvania in the United States of America. At the time of her death she lived at 322 South Fayette Street in Alexandria in the United States of America. She was married and was a retired Lieutenant Colonel in the United States Army.

Injury or disease causing death
1a Multiple Injuries

Time, date, place and circumstances at or in which injury was sustained
On 3rd January 2012 Eileen Larrimore was a passenger on a tour company cruise to South Georgia. She was a member of a walking party carrying out the last part of the Shackleton Walk, a walk between Fortuna Bay and Stromness. The walk was being guided by staff from the tour company and the route had been chosen by the walk leader.

The walking party had reached the highest point on the walk and was descending towards a stream when she lost her footing, tripped, lost her balance and fell over. She then began to tumble and then slide forwards, building up speed. She was unable to stop herself from sliding. Her husband became aware of what was happening and grabbed out at her to try and stop her. He too was carried along by the momentum. They slid forwards and fell over a cliff that was close to the path and into a ravine below.

Eileen Larrimore died as a result of multiple injuries that she sustained in the fall.

The route that was being followed by the party was not the official one set out by the South Georgia Government in their Visitor Management Plan, a copy of which the walk leader had been provided with. She had not been told of the presence of the cliff at the point where she fell, either at the pre-walk briefings or at any time during the walk. No member of staff was at that point in the walk warning of the presence of the cliff.

The medical attention thereafter shown to Mrs Larrimore did not meet the universally defined and recognised ABCDE method for dealing with trauma. However, given the nature and extent of her injuries, and the remote setting of the incident, it was unlikely that she would have survived in any event.

Eileen Larrimore died at approximately 2:21pm on 3rd January 2012 on the route of the Shackleton Walk on the descent into Stromness harbour, in the British Overseas Territory of South Georgia.

Conclusion of Coroner as to death
Died as a result of multiple injuries sustained in a fall.

I will send the Coroner's Inquisition to the Registrar General in the next few days which will allow for Mrs Larrimore's death to be formally registered and a Death Certificate to be issued.

Rule 39 of the Coroner's Rules of the Falkland Islands, states that *"if the coroner believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which*

the inquest is being held he may announce at the inquest that he is reporting the matter in writing to the person in authority who may have power to take such action and he may report the matter accordingly."

During this Inquest I have heard evidence which has given me cause to believe that there is such action that should be taken.

In coming to this view I am also conscious that life involves risks and that greater risks than the norm are inevitable if the boundaries of human experience are to be pushed, in this case in travel to places where, but a few years ago, it would not have been possible. However, risks must be assessed and managed if the chances of tragedies such as this are to avoided in future.

In particular:

1) It became apparent to me that there is a lack of knowledge and understanding, and considerable confusion as to what the obligations are upon walk leaders on South Georgia, and other members of expedition staff. There is a lack of clarity as to whether Visitor Management Plans are in force, in place or are required to be followed. Clearly the following of pre-determined routes which are as safe as circumstances can allow is a major factor in preventing injuries or deaths. It was of particular note to learn that the official Shackleton Walk route did not have any steep cliffs, drop or ravines on it. Part of this lack of knowledge and confusion might have arisen by the apparent tendency of Zegrahm to use independent contract arrangements for those working for them rather than employment contracts. In essence there seemed to be a very disjointed system of any form of management structure, which might have led to important information not being communicated as effectively as it could have been to those actually leading the expeditions.
   Of particular concern to me was to hear evidence from Dr Collins that it would seem that, as late as a week or so ago, there was evidence that tour groups are still not following the official route as, on the evidence that I heard, tracks were found at the site of the incident location.

    - It may be that further education is required of the tour companies as to the policies that are in force on South Georgia and the permitted walking routes in particular.
    - It may be that there needs to be a requirement in the permit application forms for all applicants to confirm that they are aware of the official routes and have trained and instructed all members of their staff and other servants and agents, to comply with them.
    - It may be that the South Georgia Government should show a tougher stance and impose penalties on those who breach their policies.
    - It may also be that the South Georgia Government should rebalance their literature to emphasise more the consequences to human safety of failing to comply with the policies and instructions rather than the present emphasis which seems weighted towards preservation of wildlife and vegetation. They may also wish to consider whether to use more prescriptive terms in their literature such as "must" for "should" and that it is "essential" or "a requirement" to follow the waypoints rather than it being merely "important" to do so.
2) I have been very concerned that the medical services provided on these cruises, to remote and hostile areas, are not adequate for the potential risks associated with the type of places visited, their remoteness and the delays which would inevitably be involved in reaching more advanced hospital treatment should that be needed. The evidence I heard and read suggested that the medical care provided both in the sense of equipment on the ship, and in respect of the knowledge in respect of trauma medicine of the doctor on board, was basic. The evidence suggested that the treatment that was provided did not follow the recognised standards of trauma care and I was concerned to hear evidence that the ship's doctor expressed concern at the lack of medical supplies that he had been provided with. Whilst it is not for me to

attempt to suggest by list exactly what equipment is needed, and I accept that the provision of medical facilities must be proportionate to any assessed risks, it does seem to me that benefit would be gained from a comprehensive review of what medical facilities and expertise should be available on trips to South Georgia and other such remote areas. Although it is right to say that the nature and severity of the injuries suffered by Mrs Larrimore were such that, whatever the level of care that could have been reasonably been provided in the circumstances of South Georgia, it was very unlikely that she could have survived, a more specialist trained doctor, with more advanced equipment might go some way to saving the life of someone who suffered less serious injuries. It may be that it is also appropriate for these matters to be considered by the Government of South Georgia with a view to them considering whether medical provision of a certain standard should be condition precedent to the grant of a permit.

3) I have been concerned that the provision of medical insurance by Zegrahm as including evacuation insurance led some of the passengers into the belief that more would be available in the event of emergency than could actually be provided in the circumstances of South Georgia. This might have led people into a false sense of security. Medivac insurance in South Georgia would realistically amount to sailing on the cruise ship itself back to the Falkland Islands or possibly to Antarctica. Those who are deciding whether to embark upon a trip such as this should be fully aware of the risks involved and the limitation of medical care so that they can properly assess whether their particular medical conditions and circumstances could be dealt with appropriately should the need arise. It seems to me that tour companies operating this kind of expedition should ensure that their literature to passengers makes the circumstances of such remote places and the limitations of their insurance clear.

I am conscious that some actions have already been taken by the Government of South Georgia following a review of their Visitor Management Plan, and changes being made to its wording to make adherence to the route more prescriptive. I have also received information that Quark are in the process of reviewing and changing their policy as to the provision of doctors on their cruise expeditions.

It is also right to say that Mr Larrimore sent letters setting out his thoughts on how visiting these Islands could be made safer, which I forwarded to the appropriate authorities of both the Falkland Islands and South Georgia for them to consider.

I therefore intend to write to Zegrahm and to the Government of South Georgia to raise these issues and to invite them to report to me in 56 days setting out what actions they propose to take. I emphasise that whilst I consider that it is my right and duty to report these matters I have no power to dictate as to what, if any, action is actually taken and what changes may result.

I also intend to write to IAATO to set out these matters and ask that they too consider and report to me what actions they propose to take.

I have now concluded the formal parts of this Inquest.

Before I rise however I would like to say the following:

I would like to thank those at the Government of South Georgia, both those in the comfort of Government House and those on the Islands itself (and those at the British Antarctic Survey and within the military) for the considerable efforts made to provide me with the best evidence they could. In particular, I am grateful to Mr McKee who has assisted this Court very considerably indeed.

I thank Mrs Padgett for her very great efforts in trying to cope with the difficulties that the Court has faced in trying to communicate with so many witnesses from around the world.

I express my thanks to the members of the Royal Falkland Islands Police who, as Coroner's Officers, have assisted me, as they always do, with this investigation, in particular PS McDade and of course DI Street. DI Street now moves away from coronial matters to other duties. I consider it important to state in public my personal gratitude for his considerable assistance in both this Inquest and in the other investigations that we have carried out together.

Those who do not work within the administration of justice in the Falkland Islands do not fully appreciate the way that resources are limited, restricted and often tightly controlled. It is a measure of the professionalism of those who have assisted me in this case that this Court has been able to hold this Inquest despite these undoubted challenges.

Finally, and perhaps most importantly, in his evidence Mr Larrimore considered that his actions in reaching out to try to save his wife, were likely to have been merely instinctive, but I consider that they were brave and selfless. I have been impressed and truly moved by the very real dignity with which Mr Larrimore has tried to deal with the tragic death of his wife. I repeat my condolences and sympathy to him and his family.

This Inquest is now closed.

The Law Courts, Town Hall, Stanley, Falkland Islands, FIQQ 1ZZ
Telephone: 00500 27271
Email: cgumsley@townhall.gov.fk