REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **SubCPartner** **Tvaekaj 2** **DK-6700 Esbjerg** **Denmark**
1	**CORONER** I am André J A Rebello, Senior Coroner for the area of Liverpool and Wirral Coroner Area
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION** On 23rd May 2012 I commenced an investigation into the death of **Stephen Owen O'MALLEY** Aged **48**. The investigation commenced on the 23rd May 2012 and was concluded on the 14th September 2015.
4	**CIRCUMSTANCES OF THE DEATH** On Thursday, 3rd May 2012, Stephen Owen OMALLEY was working as a contracted commercial diver for Sub C Partners, based in Denmark. He was working in the North Sea on the Alpha Ventus offshore wind farm, some 45km North of Borkum, Northern Germany. He had been replacing bolts on the wind farm turbines. The vessel was approximately 25m away from the turbine he was working on. He was wearing a full diving suit, with a Kirby Morgan 27 watertight helmet, with an umbilical air supply of plain compressed air supplied by the surface vessel. The air is supplied directly into the helmet at face height and he also had reserve air supply in the tanks on his back. At approx. 3:32pm, he entered the water and began pulling himself along a guide rope towards the wind turbine structure. He was working at a depth of approximately 2m. Whilst making his way along the rope, he was observed to experience breathing difficulties. He complained that his neck dam was too tight and it was restricting his breathing. He was instructed to make his way back to the vessel which he did, unaided. It was not appreciated as to the extent of his distress and difficulties until a short time after arriving back at the ladder, he became unresponsive. A rescue diver entered the water and after initially not being able to locate the C-clip on the back of his harness Mr O'Malley was eventually hooked onto a winch and taken aboard the vessel where attempts at resuscitation were commenced for approximately one hour before a doctor was flown out and confirmed he had sadly died. It is found on the balance of probabilities that Mr O'Malley has suffered a cardiac arrest as a result of hypoxia caused by his

	respiratory function being impaired by him hyperventilating as a result of difficulty in breathing from the compression on his neck from the neck dam ring. There is no evidence of any previously undiagnosed cardiomyopathy having any role in his death.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – The court has been advised that rescue of Mr O'Malley from the sea was delayed because the standby diver could not locate the c-clip on the back of his harness which was to facilitate hoisting him from the water. The Court has heard that checking this c-clip is free and accessible is not part of the standard checks before a dive. Should such a check be part of the pre-dive protocol checks?
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 10th November 2015. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Mr O'Malley's family, [redacted] and [redacted] . I have also sent it to the Marine Accident Investigation Branch of the Department for Transport in London, who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**14th September 2015** **André J A Rebello OBE** **Senior Coroner**