

IAN MICHAEL ARROW Senior Coroner for Plymouth, Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	REGULATION 20 REPORT TO PREVENT POTORE DEATHS
	THIS REPORT IS BEING SENT TO: Secretary of State for Transport, Chris Grayling, Great Minster House, 33 Horseferry Road, London, SW1P 4DR
1	CORONER - Ian Michael Arrow, Senior Coroner, Plymouth, Torbay and South Devon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
	Following an Investigation an Inquest opened on 4 October 2017.
	The findings of the Inquest Hearing on 30 April 2019 at Plymouth Coroner's Court the following was determined:-
	The deceased was Clive Anthony Jones.
	Medical Cause of Death was:- 1(a) Drowning 1(b)
	1(c) II Hypertensive Heart Disease
	The Conclusion of the Jury was the death was as the result of an Accident.
4	CIRCUMSTANCES OF THE DEATH
	On 26 September 2017 the deceased was on his own boat when the crew attempted to haul in an excessive weight within the net that had trawled. The net drum failed and accordingly an ad hoc arrangement was used which consisted of lifting the net through a higher block on to the transom but due to the weight it caused the vessel to list heavily to port. The vessel was unstable and capsized. The deceased was trapped in the wheelhouse where he drowned. His body was later recovered by Navy divers.
5	CORONER'S CONCERNS
	During the course of the inquest the evidence 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
	(1) At the Inquest MAIB Inspector Mr Flegg gave evidence of various procedures and policies. Most important amongst these were the recommendations made by MAIB which were as set out in Section 5 of his report (and are annexed) that there be an independent review of the UK Search and Rescue operational capability and Her Majesty's Network Coastguard

	functionality. (2) To conduct a thorough review of Search and Rescue information technology systems to ensure a reliable network.
6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you as Secretary of State have the power to ensure the recommendations are followed. I would ask you please to report to me firstly that the recommendations have been actioned and subsequently ask that you or your successor report to me once the reviews have been concluded and if a report is produced provide me please with a copy and the relevant review report.
	I shall be sharing both of these documents with the Chief Coroner.
7	YOUR RESPONSE
	You are under a duty to respond to this report within 56 days of the date of this report, namely by 26 June 2019. 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, (MIAB Inspector) and the Next of Kin
	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	Dated:- 30 April 2019
	SignatureI M Arrow, Senior Coroner