REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Maritime and Coastguard Agency, Head Office, Spring Place, 105 Commercial Road Southampton, SO15 1EG**
1	**CORONER** I am Jonathan Mark Layton Senior Coroner, for the coroner area of Carmarthenshire and Pembrokeshire.
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 and INQUEST** On 29th April 2016 I opened an investigation into the death of Gareth Willington and on the 24th October 2016 I opened an investigation into the death of Daniel James Willington. The investigation concluded at the end of the inquest on 10th November 2016. The conclusion of the inquest was accidental death in relation to Daniel James Willington and misadventure in relation to Gareth Willington.
4	**CIRCUMSTANCES OF THE DEATHS** (1) On 28th April 2016 Gareth Willington and his son Daniel James Willington left their homes to go out on their fishing boat called Harvester leaving Milford Haven Docks in the early hours. (2) At 14.30 hours that day the coastguard received calls in relation to a fishing boat in difficulty near Abereiddy. (3) The emergency services were alerted and a full scale search was commenced in the area. (4) At 18.00 hours Mr Gareth Willington was recovered from the sea and taken to Withybush General Hospital where life was pronounced extinct. (5) The body of Mr Daniel James Willington was not recovered. (6) A report from the MAIB concluded that Mr Daniel Willington had become entangled in the back rope and Mr Gareth Willington had come to his assistance resulting in both men going overboard. (7) Neither crew member was wearing a personal flotation device at the time of the accident.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed this matter 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** is as follows: That the wearing of personal flotation devices whilst on deck is not mandatory. The

	report from the MAIB in their report no 22/2016 states "the benefits of wearing PFDs on the exposed decks of fishing vessels are incontrovertible". Legislation requiring the compulsory wearing of personal flotation devices on the working decks of fishing vessels while at sea would lead to a reduction in the number of deaths at sea.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 the 5th January 2017. 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: [redacted] 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	**10 November 2016** **Signed: J M Layton**