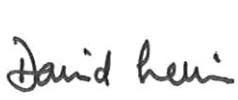
David Lewis
Assistant Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Maritime & Coastguard Agency, Spring Place, 105 Commercial Road, Southampton SO15 1EG
1	**CORONER** I am David Lewis, Assistant Coroner for North Wales (East and Central)
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 14 July 2023, sitting with a jury, I heard simultaneously the inquests into the deaths of three men (Ross Stephen Ballatine, Carl Stephen McGrath, Alan Wallace Minard), each of whom died from immersion/drowning after the fishing vessel on which they were working (Nicola Faith) capsized off the coast of North Wales on 27 January 2021. In each case the jury returned a narrative conclusion in the same terms: ".[The Deceased] died from immersion/drowning after the capsize of the fishing vessel which he was working on. The boat capsized due to the combination of the modifications of the vessel, the weight and distribution of the catch and equipment and its effect on the stability of the vessel".
4	**CIRCUMSTANCES OF THE DEATH** The vessel set sail on the morning of 27 January 2021 with its skipper and two other fishermen (the three deceased) on board. Their intention was to collect whelks for sale. The vessel capsized at around 18:00. The bodies of the three men were washed ashore at various points around the coast of North West England around 7 weeks later. The vessel had been given a safety certificate following an inspection by the Maritime and Coastguard Agency in September 2017. Thereafter the vessel was modified in a number of ways, to improve functionality. The changes adversely affected the stability of the vessel. The vessel was inspected again twice by the same inspector from the Agency, in May 2019 and December 2020, following incidents which had been brought to the Agency's attention b**y** the Holyhead Coastguard. The inspector did not consider that the changes he witnessed warranted a formal stability assessment. He placed great weight upon his impression of the skipper's competence and intentions concerning operational procedures. It is likely that the vessel could have operated safely (in relatively calm waters, such as existed on the day of its capsize) with a load of up to 1 Tonne; but its actual load (which had not been distributed appropriately) was calculated to be closer to 4.6 Tonnes.

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. – Although I was somewhat reassured to learn that the relevant Regulations have been revised and strengthened since these events, I am concerned that in this case (and, therefore, possibly in other cases) the Agency did not establish or apply a clear threshold in determining the need for a full stability assessment to be performed following significant modifications to the vessel. Too much reliance was placed on: (1) reassurances offered by the skipper of the vessel in relation to his appreciation of risk and/or his operational intentions (notably about the size and distribution of the load); and (2) informal visual assessments of the impact of the modifications which were undertaken whilst the vessel was in dock and was not under loaded conditions. In addition, insufficient concern arose from the issues identified on the two occasions when Holyhead Coastguard advised the Agency of the need to rescue the vessel following breakdowns at sea. I am concerned that other vessels (whether or a similar size or otherwise) may be operating, which have been modified since the issue of the original safety certificate and which require a full stability assessment before their operational safety can be properly evaluated.
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 11th of September 2023 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 Family of the Deceased, the MAIB and to the Chief Coroner. 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 17th July 2023  Signature Assistant Coroner for North Wales (East and Central)