

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. The Rt Hon Patrick McLoughlin, MP, Secretary of State for Transport2. Sir Alan Massey, Chief Executive, Maritime and Coastguard Agency3. [REDACTED] Director of Standards, British Standards Institution4. [REDACTED] Head of Technical Policy, British Standard Institution
1	<p>CORONER</p> <p>I am Maria Voisin, Senior Coroner, for the area of Avon.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 17th February 2011 I commenced an investigation into the death of Gerardo Abadilla TONOGBANUA, aged 23. The investigation concluded at the end of the inquest commenced on 28th April 2014. The conclusion of the inquest was</p> <p>Cause of death: 1a Mediastinal haemorrhage 1b Traumatic rupture of aorta</p> <p>Conclusion: Mr. Tonogbanua died as the result of an accident</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>The Jury concluded that on the 7th February 2011 Mr. Tonogbanua fell 29 metres during a fast rescue boat drill onboard the MV Tombarra while docked at Royal Portbury Dock, Bristol. The rescue boat and Mr. Tonogbanua fell when the fall wire hoisting the rescue boat back onto the Tombarra snapped. The wire snapped because the power of the winch motor was incompatible with the strength of the fall wire. On this occasion the motor continued running past the stowed position because the proximity switch which would normally stop the motor failed. Despite efforts to resuscitate Mr. Tonogbanua he was subsequently pronounced dead at Bristol Royal Infirmary, Bristol.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none">1. The fall wire of MV <i>Tombarra's</i> rescue boat failed because the winch electric motor was capable of easily overstressing the fall wire to the point of failure. There is currently no requirement within the Life-Saving Appliances (LSA) Code to consider design of the rescue boat lifting davit, winch and fall wire, as a 'system' when assessing the suitability of the forces and loads applied. The Code infers that 'overstressing' of the falls or davits could occur.2. An electronic switch, fitted to the rescue boat davit onboard <i>Tombarra</i>, failed to operate and stop the winch motor. The LSA Code refers to 'safety devices' fitted to the davits which will automatically cut off the winch power to prevent overstressing of components. This is reflected in the international standard ISO

	<p>15516 "ships and marine technology-launching appliances for davit-launched lifeboats". However, neither the Code nor the standard specify the number, definition or performance of the 'safety devices' fitted. Consequently, manufacturers have little guidance in these areas compared to manufacturers of industrial machinery</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe that one or more of your organisations have the power to take such action.</p> <ol style="list-style-type: none"> 1. The Marine Accident Investigation Branch (MAIB) report (19a/2012) into the failure of the fall wire made a recommendation (2012/128) to the MCA to submit proposed changes to the Life Saving Appliances (LSA) Code to reflect a 'system approach' to davit and winch installations. This recommendation should be progress accordingly. 2. The British Standard Institution (BSI) should liaise with the MCA through the appropriate BSI committee to propose amendments to ISO standard 15516 along the following lines: <ul style="list-style-type: none"> Subclause 5. 3. 4 should be amended to include: <p><i>"Where overstressing cannot be prevented by the design of the davit system, the safety devices and their associated control circuit shall be:</i></p> <ol style="list-style-type: none"> 1. <i>Intended by their manufacturer for that purpose and environment;</i> 2. <i>The circuit shall be tolerant of at least one fault;</i> 3. <i>The circuit shall be equipped with means of detecting and indicating faults;</i> 4. <i>The instructions provided shall describe the actions to be taken when a fault is detected.</i>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by Thursday 24th July 2014. I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons – the family of Mr. Tonogbanua, Wilhelmsen Lines Care Carriers Ltd, Norsafe, Lloyds Register, Harding Safety and Schneider Electrics.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>27th May 2014</p> <p style="text-align: right;">M. E. Voisin Senior Coroner</p> 