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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. Plateus Ltd** PO Box 3162, Rawlinson & Hunter Woodbourne Hall Roadtown Tortola British Virgin Islands
	CORONER **I** am Philip Alan Sharp, Assistant Coroner, for the Coroner area of Cumbria
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 the 23rd April 2013 I commenced an investigation into the death of Michael Robert Hanlon who was born on the 8th December 1990. The investigation concluded at the end of the inquest on 27th May 2015. The conclusion of the inquest was that Michael died from 1(a) Drowning. His death was an accident.
4	**CIRCUMSTANCES OF THE DEATH** On the 6th April 2013 Michal Robert Hanlon as a deckhand on a luxury boat M.Y.FAITH owned by you. It came in to Antibes Harbour. He had worked a night watch and then worked for the whole of the 6th April 2013 without rest or sleep. He with other members of the crew went out in to Antibes to meet friends. He returned to the boat at approximately 11.30p.m but did not enter it. He was seen walking on the boat until 00.11 on the 7th April 2013. At some point later before 00.22 he fell from the upper deck of the boat hitting the quay before drowning in the harbour.

5	**CORONER'S CONCERNS** During the Inquest it became apparent that members of the crew had failed to gain entry to the boat on returning from on shore. One crewmember had slept on deck. I also concluded one crewmember had attempted to climb through a doorway on the upper deck near to the position where the deceased had fallen. There was a possibility, but no finding was made, that the deceased may have been endeavouring to enter the boat by this route when he fell. I also concluded crewmembers and in this case the deceased were likely to have been asked to work additional shifts when the boat came in to port, potentially causing tiredness amongst crewmembers. Further the deceased's work pattern did not match the shift rota and his time sheet was not made up to the time of his last shift. The system for entering the boat after 10.00p.m involved certain members of the crew having a key, but otherwise requiring knowledge of a key code to obtain a key from a box situated at the front of the boat. The key could then be taken to the entry door at the rear of the boat, a door opened and then the key returned to the front of the boat in to the key box before the crewmember would then enter the open door.
6	The **MATTERS OF CONCERN** are as follows:- (i) The efficacy of the entry system for certain crewmembers who were returning to the boat after 10.00pm. (ii) The recording of and monitoring of crew working hours by the officers to ensure crewmembers are not required to work additional hours unless the safety of the boat, crew and passengers was in danger.
7	**ACTION REQUIRED** In respect of:- 6 (i) above: To provide all crewmembers with a key to enter the boat save when the owners/guests were on board when a 24 hour watch should be implemented. 6 (ii) above: To ensure that all officers properly record the crews shift rota and that working hours are recorded daily and the captain should check periodically that this policy is being maintained and overtime work justified to him when needed.

8	**YOUR RESPONSE** Is required on the 31st August 2015
9	**COPIES and PUBLICATION** I will send copies to: 1. The family of Michael Hanlon 2. Marine Response Insurers of M.Y.FAITH 3. United Kingdom Sailing Association. 4. The Maritime Coastguard Agency. 5. Cayman Maritime.
10	**DATE: 23rd July 2015** **SIGNED BY CORONER** **P A Sharp** **……** Philip Alan Sharp