Grahame Antony Short
Senior Coroner for Southampton & New Forest

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Primebulk Shipmanagement Limited**
1	**CORONER** I am Grahame Antony Short, Senior Coroner for Southampton & New Forest
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** On 25/05/2016 I commenced an investigation into the death of Gerome Baon Reyes, 26. The investigation concluded at the end of the inquest on 12 January 2017. The conclusion of the inquest was Accidental death. I determined that at about 11.20 (GMT + 2 hours) on 22 May 2016 whilst on board MV Moonray sailing across the North Sea approximately 25 miles east northeast of North Foreland and in international waters, messman Gerome Reyes was alone in the galley unloading a goods lift when he activated the lift whilst its door was open and was dragged up as the lift ascended, as a result of which he sustained traumatic multiple injuries. No door limit switch was fitted to the lift so that it could be operated whilst the door was open. He died as a result of Head and Trunk Injuries
4	**CIRCUMSTANCES OF THE DEATH** The death would not have occurred if the door limit switch had been fitted to the goods lift being operated by the deceased.
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) The Deputy Commissioner of Maritime Affairs for the Republic of the Marshall Islands made recommendations for the relevant goods lift on MV Moonray not to be brought back into service until door limit switches were installed. There has been no confirmation that this recommendation has been acted upon. (2) It appears to me possible that other ships of the same design may also have goods lifts installed without door limit switches being installed and so there is the potential risk of injury or death if they are operated in similar circumstances. There is no confirmation that Marine Safety Advisory No. 20-13 issued on 26 May 2016 has been implemented.

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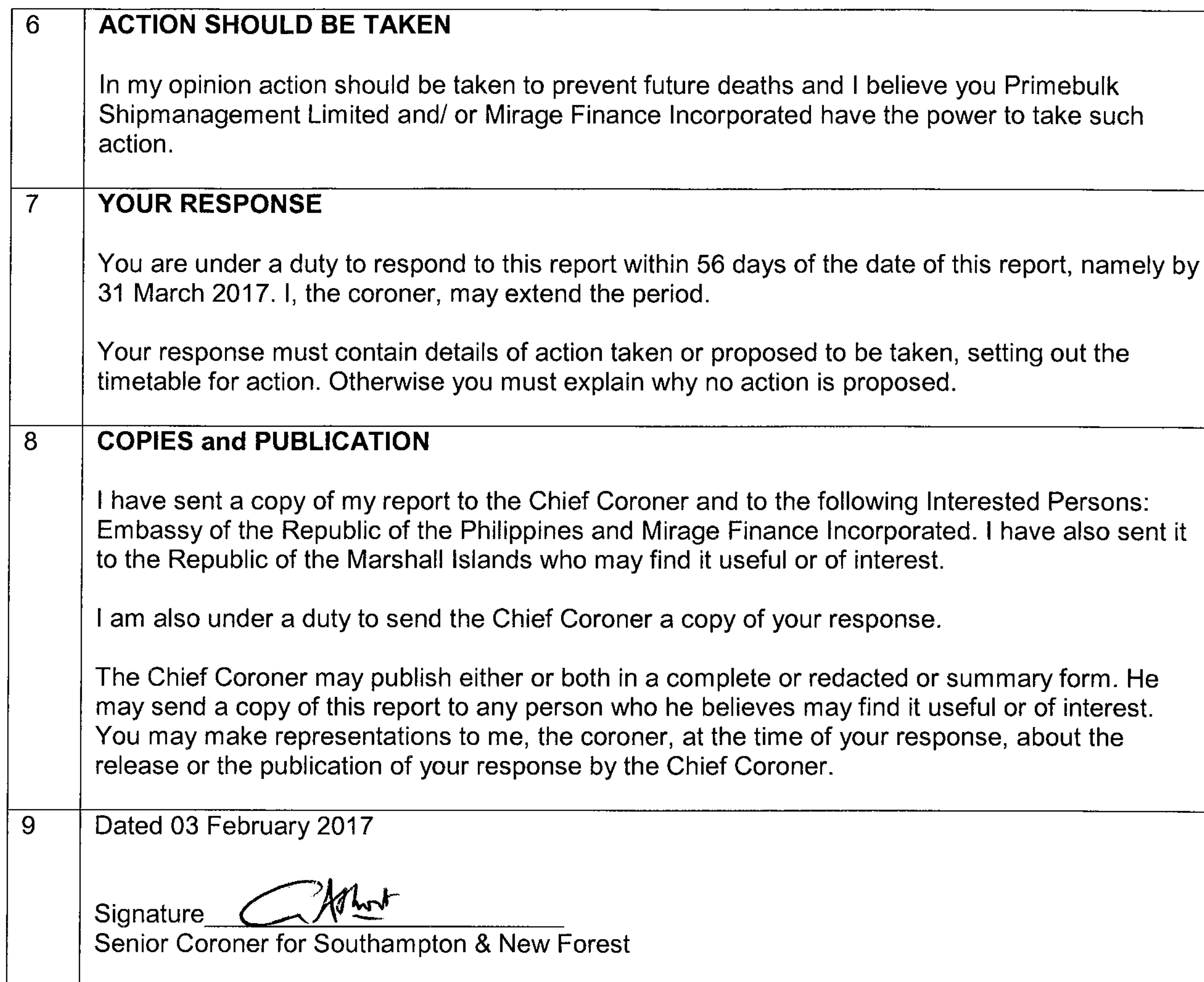

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Primebulk Shipmanagement Limited and/ or Mirage Finance Incorporated have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 31 March 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: Embassy of the Republic of the Philippines and Mirage Finance Incorporated. I have also sent it to the Republic of the Marshall Islands who may find it useful or of interest. 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 03 February 2017 Signature____________________ Senior Coroner for Southampton & New Forest

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