REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Secretary General** **International Maritime Organisation** **4 Albert Embankment** **London** **SE1 7SR** **Vantage Drilling Company** **777 Post Oak Blvd** **Suite 800** **Houston** **Texas** **77056** **USA**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 21st March 2016 I commenced an investigation into the death of Jeremy Sutch. The investigation concluded at the end of the inquest on 13th February 2019. The conclusion of the inquest was that; Jeremy Sutch died on the 25th February 2016 at 20:20 in Labuan Hospital, Labuan, Malaysia from injuries received earlier in the day (at around 14:50) on the MV Platinum Explorer, which was moored off the coast nearby. He sustained his injuries when he was crushed by a Riser Feeding Machine on board the vessel. His medical cause of death following a post-mortem examination was 1a Blunt Chest Trauma.
4	**CIRCUMSTANCES OF THE DEATH** Jeremy Sutch was a Trainee Driller on board the MV Platinum Explorer, when it was moored in Kuraman Island Water, off Labuan, Malaysia on Thursday the 25th February 2016. At approximately 14.55 hours a telephone call was made to the bridge of the Platinum Explorer by Jeremy, requesting help in the Drillers Control Cabin. Other members of the crew attended the Driller's Control Cabin and found Jeremy injured on the floor. He told them he had been crushed by 'the RFM bucket' (on a Riser Feeding Machine).

	Jeremy was struggling to speak and when found by other members of the crew had injuries to his chest. Jeremy was given first aid attention by the on-ship paramedic. A 'medevac' casualty evacuation was arranged and carried out by a small tender vessel in order to get Jeremy to the nearest land (some 30 to 40 minutes away). Once ashore Jeremy was taken to the Hospital in Labuan where, he tragically passed away.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you; the **MATTERS OF CONCERN** as follows:- It was heard in evidence that the captain of the MV Platinum Explorer, on hearing that Jeremy had suffered crush injuries to the chest referred to The Ship Captain's Medical Guide. The court was told that this book, or similar, is carried on every vessel to advise a ship's captain on what action to take in relation to the treatment of the casualty. Following the guidance given in The Ship Captain's Medical Guide the captain instructed the crew that they must not lay Jeremy down and he should be evacuated in the sitting position. Jeremy was in such pain that he could not physically lie down in any event. As a result Jeremy was not placed in a 'basket' or 'Neil Robinson' stretcher but was sat in a 'wheelchair' type extraction chair. In evidence it was heard that there had never been an evacuation drill undertaken on board using an extraction chair (a basket type stretcher and mannequin always being used). Further, the captain said in his 42 years at sea he had never seen a medical evacuation drill, or real medical evacuation using a wheelchair type extraction chair. The fact that the crew were unfamiliar with the wheelchair extraction stretcher needed in Jeremy's case, led to the follow. • Unlike a basket stretcher the wheelchair extraction stretcher had no independent lifting points so could not be lowered to the tender by crane. • It therefore was necessary to lower the wheelchair in the crane work basket. • The wheelchair stretcher would not fit in the crane work basket and had to be dynamically modified in order for it to fit. • The crane work basket was too large and heavy to be manoeuvred into the rear of the waiting tender (which was fibreglass and risked damage). • The crane work basket was therefore lowered onto the roof of the tender wheel house. • The wheelchair stretcher would not fit down the spiral stairs leading to the passenger/casualty space inside the tender.

	• Initially the tender tried to make shore with Jeremy on the roof of the wheel house but the handrail began to give way in heavy-seas so the tender had to return to the lee ward side of the MV Platinum Explorer. • Despite his injuries Jeremy had to physically lower himself one step at a time into the passenger space of the tender before he could be taken ashore to receive medical attention. It was clear from the evidence that the issues identified above led to delay in Jeremy's medical evacuation. It was also clear that without Jeremy's own personal strength and determination he would not have been able to get inside the tender to be taken ashore. It was confirmed by a forensic pathologist at the inquest, that in his opinion Jeremy's injuries were not survivable and that any delay in his medical evacuation did not affect the tragic outcome of this case. That said, I am concerned that should a similar situation arise with a casualty whose injuries may be survivable, their chance of survival would be reduced by the delays caused by the difficulties identified in this case. I am also concerned that other captains on other ships may be unaware of the difficulties posed in the medical evacuation of a casualty when The Ship Captain's Medical Guide dictates that they must be kept in a seated position. I am further concerned by the apparent lack of knowledge of this type of casualty extraction device, which in turn resulted in an apparent lack of training drills designed specifically with its use in mind.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or your organisation 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 18th April 2019. I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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. Members of Jeremy's family and International SOS. I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**22th February 2019** N.Pg **Nigel Parsley**