ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Square Sail Charlestown Harbour St Austell PL25 3NJ
1	**CORONER** I am the Assistant Coroner for the Coroner area of Cornwall
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 3rd February 2016 at the City Hall in Truro I conducted the inquest into the death of a young man called Christopher Tristan Broom.**
4	**CIRCUMSTANCES OF THE DEATH** The brief facts were that Christopher Broom, accompanied by his girlfriend, was fishing from the harbour wall at Charlestown. It was about 11 p.m. at night on the 6th September 2015. Sadly, and it was not quite clear how, he fell into the water and drowned. He could not swim.
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 two **MATTERS OF CONCERN** are as follows. – The first is that there was only one lifebelt available. This was some distance from where Mr Broom was fishing and was very difficult to spot. Witnesses thought a lifebelt may have helped Mr Broom to survive. The second is that there was no lighting at the end of the harbour wall so that visitors to the harbour at night could not judge where the wall ended and in addition made the aforementioned lifebelt almost invisible.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, or your organisation has the power to take such action. • Extra lifebelts positioned around the harbour. • Adequate lighting to be installed.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th April 2016. 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 [REDACTED] (mother). 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	**[DATE]** 7.2.16 **[ASSISTANT CORONER]** B.J. van den Berg