### **REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

#### THIS REPORT IS BEING SENT TO:

- 999 Liaison Committee, Department of Culture Media and Sport, Brexit Strategy & Trade, Fixed Telecoms & Market Regulation, Digital Infrastructure Directorate, 100 Parliament Street, London SW1A 2BQ
- Legal Services, London Ambulance Service NHS Trust, 220 Waterloo Road, London SE1 8SD

#### 1 CORONER

I am Xavier Mooyaart, an assistant coroner in the coroner area of London Inner South.

### 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

An inquest in to the death of Robert Cobbina was opened on 13 December 2018. The inquest was concluded at a hearing on 10 June 2019. The conclusion of the inquest was misadventure.

# 4 CIRCUMSTANCES OF THE DEATH

Mr Cobbina left his home at c.0900 on 2 November 2018. His clothes were found by the River Thames at c.1030 by his wife. She called 999 and informed the control room that she believed he had gone in to the river. She was connected to the London Ambulance Service. Mr Cobbina was subsequently retrieved from the river that afternoon, and he was pronounced as life extinct at the shore. There was no evidence that in his particular circumstances Mr Cobbina would have been saved had he be found sooner.

## 5 CORONER'S CONCERNS

## 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. That neither the initial caller, nor a passer-by who continued the call with the emergency control room, were prompted to request the coastguard or other waterborne assistance despite making clear that the emergency related to a person in the river. While it is understood that each service can subsequently involve other services as required, the concern inevitably arises that there was a potentially significant delay in involving the appropriate assets to locate Mr Cobbina which could have been avoided at the point at which the call was triaged and/or.
- 2. That neither the initial caller, nor the passer-by were prompted to identify existing signage placed along the riverfront providing a coastguard location reference to be provided in an emergency situation to enable a swift and precise arrival on scene in the absence of a normal address reference.

It is acknowledged that this may have been an isolated instance but the concern remains that callers identifying an emergency related to someone in the river may not always be sufficiently interrogated, appropriately triaged, or be served with the appropriate assets as soon as may be possible, and that in other circumstances there is a risk that death will occur unless action is taken to ensure this is not systemic. **ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by August 20th 2019. 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. **COPIES and PUBLICATION** 8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: -(Wife) 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] [SIGNED BY CORONER] 25<sup>th</sup> June 2019 **Xavier Mooyaart - Assistant Coroner**