	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Secretary of State for Transport** **2. The Health and Safety Executive** **3. The Chairman of the National Water Safety Forum** **4. The Operations Director RNLI** **5.** [redacted] **6.** [redacted] **7.** [redacted] **Birnberg Peirce Solicitors** **8. Royal Society for the Prevention of Accidents** **9. Local Government Association** **10. The Chairman, Rother District Council** **11. Maritime and Coastguard Agency** **12. East Sussex Divisional Commander, Sussex Police**
1	**CORONER** I am ALAN ROMILLY CRAZE, Senior Coroner, for the coroner area of East Sussex.
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 24th of July 2016 I commenced an investigation into the death of GUSTAVO SILVA DA CRUZ. On 29th of July 2016 I opened an investigation into the death of MOHIT DUPAR. On 25th of August 2016 I opened investigations into the deaths of INTHUSHAN SRISKANTHARASA, GURUSHANTH SRITHAVARAJAH, KENUGEN SATHTHIYANATHAN, KOBIKANTHAN SATHTHIYANATHAN and NITHARSAN RAVI. The investigations concluded at the inquest into all seven deaths on 30th June 2017. The conclusions of the inquests are summarised on the seven Record of Inquest forms, copies of each I have attached to this letter.
4	**CIRCUMSTANCES OF THE DEATH** On 24th of June 2016 Mr. Da Cruz and Mr. Dupar went into the sea at Camber Sands, Rye. Mr. Da Cruz was seen to be in difficulties and his body was later washed up on the shore. Mr. Dupar was seen to be in difficulties and was brought to the beach unconscious. He had suffered from hypoxic brain damage and died at Ashford Hospital, Kent on the 28th of July. The other five deceased were all part of a party of five young Sri Lankan men who travelled together to Camber to enjoy a day at the beach on 24th of August 2016. They all went into the sea at a time when the tide had started to come in. It is not known how well any of them could swim. It is thought that they were all on a sand bar when they were overtaken and cut off by the incoming tide. All five bodies were recovered to the shore that day, or found after the tide had receded. The RNLI had recommended deploying lifeguards at the beach in 2013 but Rother District Council had not implemented that recommendation. It was accepted quite quickly after these deaths and lifeguards are now deployed. There was considerable evidence at the inquest on the question of whether that step, and others recommended, would have prevented any of the deaths. It should be noted that the length of the beach from which people can swim is about three miles and the distance between high water mark and low water mark is as much as a kilometre in some tides.

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:– (a) There are possibly lessons in the circumstances of and the issues surrounding these deaths which may be of help to others on a national basis. (b) There appears to be no formal governance or control of risk management requirements. Should the present, virtually voluntarily, structure be examined? Could perhaps the Marine and Coastguard Agency, who have enforcement powers akin to those of the Police, be given more resources and take a bigger role than they currently have? The problem is an increasing one. The evidence suggested that on a pleasant hot summer's day 25,000 to 30,000 people visit Camber Sands, many of whom have language difficulties and do not speak much English, and many others of whom have no experience of going into the sea. The question is whether leaving matters to a charity is really the best basis of a structure intended to spearhead a possibly overdue attempt to modernise, harmonise, and improve the safety regime, given so many changes at Camber. (c) Changes include:- (i) possible climate change effects, (ii) differences in ethnic origins and language spoken by current visitors, (iii) constant and fast changes in means of communication with the public, which everybody at these inquests agreed to be crucial to the necessary educative process, (iv) improvement, considered vital, of education and awareness of coastal dangers amongst children and those who live far from the sea. (d) Inevitably resource and monetary considerations affect decision making by those charged with safeguarding people like the seven who died here. Perhaps that is another reason why a review of the current system may well be needed. (e) There was pessimism expressed at the inquests that any measures could prevent most deaths, only reduce them. In those circumstances, should there be consideration by central government of taking powers to restrict public use, according to daily circumstances, of parts or all of certain beaches? Certainly a localised study, on a national model, should be carried out. I believe it has elsewhere in the world.
6	**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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 18th September 2017. I, the Coroner, may extend this 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 all those persons or organisations names at the head of it. 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	Two expert witnesses gave evidence at the inquests and one of them, [redacted] of Middlesex University, offered a paper raising 12 issues which I have attached to my Regulation 28 Report because it may assist discussion (Appendix A).
10	**Dated 24th July 2017** **Signed**..... Alan R. Craze H.M. Senior Coroner East Sussex

Record of Inquest

Following an investigation commenced on the 24th day of July 2016
And Inquest opened on the 2nd day of August 2016;
At an inquest hearing at Muriel Matters House on the 26th day of June 2017 heard before ALAN ROMILLY CRAZE Senior Coroner in the coroner's area for East Sussex, the following findings and determinations were made:

1. Name of Deceased (if known)

Gustavo SILVA DA CRUZ

2. Medical cause of death

Ia **Drowning**

b

c

II **Asthma**

3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death

On 24th July 2016 the deceased, who was an asthma sufferer, went into the sea at Camber Sands to bathe. He was seen to get into difficulties and his body was later washed up on the shore. He was deceased and rigor mortis had set in. The RNLI had recommended, amongst other measures, deploying life guards at the beach in 2013 but this had not happened. Of course it is not known whether such a step would have prevented his death, but it has since been implemented.

4. Conclusion of the Coroner as to the death

Misadventure

5. Further particulars required by the Births and Death Registration Act 1953 to be registered concerning the death

(a) Date and place of birth **25 December 1996** **Brazil**	
(b) Name and Surname of deceased **Gustavo SILVA DA CRUZ**	
(c) Sex **Male**	(d) Maiden surname of woman who has married ---
(e) Date and place of death **Twenty - Fourth July 2016** **Camber Sands Beach, Camber, Rye, East Sussex**	
(f) Occupation and usual address --- **Maestro Sebastiao Peranovich 353, Atibaia, Sao Paulo, 12942260**	

Signature of Senior Coroner ..... **ALAN ROMILLY CRAZE**

Record of Inquest

Following an investigation commenced on the 29th day of July 2016
And Inquest opened on the 9th day of August 2016;
At an inquest hearing at Muriel Matters House on the 26th day of June 2017 heard before ALAN ROMILLY CRAZE Senior Coroner in the coroner's area for East Sussex, the following findings and determinations were made:

1. Name of Deceased (if known)

Mohit DUPAR

2. Medical cause of death

la **Hypoxic brain injury**

b **Out of hospital cardiac arrest**

c **Drowning**

ll

3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death

On 24th July 2016 the deceased was seen to be in difficulties in the sea at Camber Sands, Rye. He was brought to the beach unconscious. He was taken to Ashford Hospital suffereing from hypoxic brain damage and died there on 28th July 2016. The RNLI had recommended, amongst other measures, deploying lifeguards at the beach in 2013 but this had not happened. Of course it is not known whether such a step would have prevented his death, but it has since been implemented.

4. Conclusion of the Coroner as to the death

Misadventure

5. Further particulars required by the Births and Death Registration Act 1953 to be registered concerning the death

(a) Date and place of birth **30 November 1979** **India**	
(b) Name and Surname of deceased **Mohit DUPAR**	
(c) Sex **Male**	(d) Maiden surname of woman who has married ------
(e) Date and place of death **Twenty - Eighth July 2016** **William Harvey Hospital, Ashford, Kent**	
(f) Occupation and usual address **Construction Worker Husband of Irena Dupar, Housewife** **25 Cranmer Road, Hayes, Middlesex**	

Signature of Senior Coroner ..... **ALAN ROMILLY CRAZE**

Record of Inquest

Following an investigation commenced on the 25th day of August 2016
And Inquest opened on the 6th day of September 2016;
At an inquest hearing at Muriel Matters House on the 26th day of June 2017 heard before ALAN ROMILLY CRAZE Senior Coroner in the coroner's area for East Sussex, the following findings and determinations were made:

1. Name of Deceased (if known)

Inthushan SRISKANTHARASA

2. Medical cause of death

1a **Immersion (drowning)**

b

c

II

3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death

The deceased one of a party of 5 young Sri Lankan men who travelled to Camber to enjoy a day at the beach on 24th August 2016. They all went into the sea, at a time when the tide had started to come in. It is thought they were all on a sandbar when they were overtaken and cut off by the incoming tide. All five bodies were recovered to the shore deceased or found after the tide receeded. The RNLI had recommended deploying life guards at the beach in 2013 but this had not happened. Of course it is not known whether such a step would have prevented his death, but it has since been implemented.

4. Conclusion of the Coroner as to the death

Misadventure

5. Further particulars required by the Births and Death Registration Act 1953 to be registered concerning the death

(a) Date and place of birth **27 March 1993** **Sri Lanka**	
(b) Name and Surname of deceased **Inthushan SRISKANTHARASA**	
(c) Sex **Male**	(d) Maiden surname of woman who has married ----------
(e) Date and place of death **Twenty - Fourth August 2016** **Camber Sands Beach, Camber, Rye, East Sussex**	
(f) Occupation and usual address **Shift Manager** **26a Chadwell Road, Grays, Essex**	

Signature of Senior Coroner ..... **ALAN ROMILLY CRAZE**

Record of Inquest

Following an investigation commenced on the 25th day of August 2016
And Inquest opened on the 6th day of September 2016;
At an inquest hearing at Muriel Matters House on the 26th day of June 2017 heard before ALAN ROMILLY CRAZE Senior Coroner in the coroner's area for East Sussex, the following findings and determinations were made:

1. Name of Deceased (if known)

Gurushanth SRITHAVARAJAH

2. Medical cause of death

la **Immersion (drowning)**

b

c

ll

3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death

The deceased was one of a party of 5 young Sri Lankan men who travelled to Camber to enjoy a day at the beach on 24th August 2016. They all went into the sea, at a time when the tide had started to come in. It is though they were all on a sandbar when they were overtaken and cut off by the incoming tide. All five bodies were recovered to the shore deceased or found after the tide receeded. The RNLI had recommended deploying life guards at the beach in 2013 but this had not happened. Of course it is not known whether such a step would have prevented his death, but it has since been implemented.

4. Conclusion of the Coroner as to the death

Misadventure

5. Further particulars required by the Births and Death Registration Act 1953 to be registered concerning the death

(a) Date and place of birth **26 August 1988** **Sri Lanka**	
(b) Name and Surname of deceased **Gurushanth SRITHAVARAJAH**	
(c) Sex **Male**	(d) Maiden surname of woman who has married ---
(e) Date and place of death **Twenty - Fourth August 2016** **Camber Sands Beach, Camber, Rye, East Sussex**	
(f) Occupation and usual address **Student & Shop Assistant** **37 Elsa Road, Welling, Kent**	

Signature of Senior Coroner ..... **ALAN ROMILLY CRAZE**

Record of Inquest

Following an investigation commenced on the 24th day of August 2016
And Inquest opened on the 6th day of September 2016;
At an inquest hearing at Muriel Matters House on the 26th day of June 2017 heard before ALAN ROMILLY CRAZE Senior Coroner in the coroner's area for East Sussex, the following findings and determinations were made:

1. Name of Deceased (if known)

Kenugen SATHTHIYANATHAN

2. Medical cause of death

Ia **Immersion (drowning)**

b

c

II

3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death

The deceased was one of a party of 5 young Sri Lankan men who travelled to Camber to enjoy a day at the the beach on 24th August 2016. They all went into the sea, at a time when the tide had started to come in. It is thought they were all on a sandbar when they were overtaken and cut off by the incoming tide. All five bodies were recovered to the shore deceased or found after the tide receeded. The RNLI had recommended deploying life guards at the beach in 2013 but this had not happened. Of course it is not known whether such a step would have prevented his death, but it has since been implemented.

4. Conclusion of the Coroner as to the death

Misadventure

5. Further particulars required by the Births and Death Registration Act 1953 to be registered concerning the death

(a) Date and place of birth **16 December 1997** **Sri Lanka**	
(b) Name and Surname of deceased **Kenugen SATHTHIYANATHAN**	
(c) Sex **Male**	(d) Maiden surname of woman who has married ----------
(e) Date and place of death **Twenty - Fourth August 2016** **Camber Sands Beach, Camber, Rye, East Sussex**	
(f) Occupation and usual address **Student** **1 Normandy Way, Erith, Kent**	

Signature of Senior Coroner ..... **ALAN ROMILLY CRAZE**

Record of Inquest

Following an investigation commenced on the 24th day of August 2016
And Inquest opened on the 6th day of September 2016;
At an inquest hearing at Muriel Matters House on the 26th day of June 2017 heard before ALAN ROMILLY CRAZE Senior Coroner in the coroner's area for East Sussex, the following findings and determinations were made:

1. Name of Deceased (if known)

Kobikanthan SATHTHIYANATHAN

2. Medical cause of death

Ia **Immersion (drowning)**

b

c

II

3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death

The deceased was one of a party of 5 young Sri Lankan men who travelled to Camber to enjoy a day at the beach on 24th August 2016. They all went into the sea, at a time when the tide had started to come in. It is thought they were all on a sandbar when they were overtaken and cut off by the incoming tide. All five bodies were recovered to the shore deceased or found after the tide receeded. The RNLI had recommended deploying life guards at the beach in 2013 but this had not happened. Of course it is not known whether such a step would have prevented his death, but it has since been implemented.

4. Conclusion of the Coroner as to the death

Misdaventure

5. Further particulars required by the Births and Death Registration Act 1953 to be registered concerning the death

(a) Date and place of birth **3 December 1993** **Sri Lanka**	
(b) Name and Surname of deceased **Kobikanthan SATHTHIYANATHAN**	
(c) Sex **Male**	(d) Maiden surname of woman who has married ----------
(e) Date and place of death **Twenty - Fourth August 2016** **Camber Sands Beach, Camber, Rye, East Sussex**	
(f) Occupation and usual address **Shop Assistant** **1 Normandy Way, Erith, Kent**	

Signature of Senior Coroner ..... **ALAN ROMILLY CRAZE**

Record of Inquest

Following an investigation commenced on the 24th day of August 2016
And Inquest opened on the 6th day of September 2016;
At an inquest hearing at Muriel Matters House on the 26th day of June 2017 heard before ALAN ROMILLY CRAZE Senior Coroner in the coroner's area for East Sussex, the following findings and determinations were made:

1. Name of Deceased (if known)

Nitharsan RAVI

2. Medical cause of death

Ia **Immersion (drowning)**

b

c

II

3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death

The deceased was one of a party of 5 young Sri Lankan men who travelled to Camber to enjoy a day at the beach on 24th August 2016. They all went into the sea, at a time when the tide had started to come in. It is thought they were all on a sandbar when they were overtaken and cut off by the incoming tide. All five bodies were recovered to the shore deceased or found after the tide receeded. The RNLI had recommended deploying life guards at the beach in 2013 but this had not happened. Of course it is not known whether such a step would have prevented his death, but it has since been implemented.

4. Conclusion of the Coroner as to the death

Misadventure

5. Further particulars required by the Births and Death Registration Act 1953 to be registered concerning the death

(a) Date and place of birth **14 February 1994** **Greenwich, London**	
(b) Name and Surname of deceased **Nitharsan RAVI**	
(c) Sex **Male**	(d) Maiden surname of woman who has married ----------
(e) Date and place of death **Twenty - Fourth August 2016** **Camber Sands Beach, Camber, Rye, East Sussex**	
(f) Occupation and usual address **Student** **101 Admaston Road, Plumstead, London**	

Signature of Senior Coroner ..... **ALAN ROMILLY CRAZE**

Appendix A
Issues raised by Professor Ball

1. Events at Camber Sands in 2016 have raised questions about beach safety at Camber Sands and more generally.

2. The risk of drowning at Camber Sands and on other UK beaches is low.

3. The risk of drowning on UK beaches is not increasing. At Camber Sands there is insufficient evidence to identify any trend.

4. Existing beach patrol services at Camber Sands have been supplemented with an RNLI lifeguard service, initially for 3 years, as a precautionary measure.

5. Firm evidence of the effectiveness of lifeguarding services is, however, lacking. Given the likely interest in lifeguard services post 2016, this needs to be corrected so that coastal authorities can make evidence based and proportionate decisions about the need for lifeguards.

6. The first and overwhelmingly important line of defence against drowning lies in the competencies and risk awareness of beach users.

7. Competency here relates mainly to an ability to swim in calm and open water. More emphasis should be placed upon training children and young people in this regard.

8. At Camber Sands various measures increase awareness of the beach hazards at that location.

9. On a national basis there is a tendency to describe beaches (and other public places) as safe. It may be time to shift to a more frank approach which provides information on the specific hazards peculiar to each location (e.g. at Camber Sands on sand banks).

10. There is some evidence from abroad that ethnicity is a significant risk factor for drowning. Given the ethnic mix of British society this should be investigated.

11. The Camber Sands Inquest has brought to light significantly different approaches to the assessment of risk and subsequent risk management choices. These have ethical and resource implications which have the potential to impact on the overall health, safety and welfare of society. The government's recent investigation of Health and Safety concluded that safety interventions should be risk based and proportionate, and evidence based. This should continue.

12. There is a tendency to entrust risk assessment to third parties. However, this task is not delegable and is best performed by those with intimate knowledge of the location.