Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]
1	**CORONER** I am Rachel REDMAN, Assistant 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 11 May 2022 I commenced an investigation into the death of Graham Ian COOMBE aged 56. The investigation concluded at the end of the inquest on 13 October 2023. The conclusion of the inquest was that: Mr G Coombe was seen sitting below Eastbourne Pier when at approximately 7.20pm on 1st May 2022 he was seen to fall in. It was possible that he was suffering from the effects of alcohol. Attempts were made to find a life saving ring on the pier and than climb over a high locked gate to access the lower pier to try to save Mr Coombes. The lifeboat arrived at 1950hrs and removed Mr Coombe to the beach were CPR was continued. Mr Coombe died on 4th May 2022 as a result of drowning.
4	**CIRCUMSTANCES OF THE DEATH** On 1st May 2022 at approximately 7.20pm Mr Coombe was seen to enter the water and then could be heard calling for help by those on the lower level of Eastbourne Pier which is not open to the public. Police were called who tried to gain access to the lower level of the pier but were obstructed by a locked gate. Eventually police were able to climb over it and made their way down to the lower level. They asked for a life saving ring which was not easily accessible nor visible. When this was eventually located and taken to the pier's lower level it was thrown to Mr Coombe but the rope was too short to reach the water as the tide was going out. The life boat was called and on arrival rescued Mr Coombe from the sea and commenced CPR which was continued on the beach. He was later taken to Royal Sussex County Hospital Brighton where he died on 4th May 2022 as a result of drowning.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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** are as follows: 1. A locked 10 foot gate prevented the police from accessing the lower level of the pier. The security officer on the pier did not have the key. Evidence was heard that only the Manager of the pier and the maintenance worker are key holders, neither of whom were at the pier on 1st May 2022. I heard evidence from the Sussex Police that a key should be kept in a key safe on the pier with the code being notified to them so that access can be obtained when necessary. 2. The life saving ring was neither in an accessible or visible place. It was in a cupboard hidden behind a bench. These safety aids should be stored visibly and be easily accessible. 3. The rope attached to the life saving ring was too short (although its length was within the prescribed regulatory guidelines) so that the buoyancy aid did not reach the water when thrown. I am concerned that the rope was of an insufficient length for the aid to reach the water at low tide. 4. I am concerned that there should be more life saving rings on Eastbourne Pier. I heard evidence that there should be one on either side of the pier half way down and one at its end.
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 8 January 2024. 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 Family I have also sent it to Sussex Police who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 10/11/2023** Rachel Redman **Rachel REDMAN** **Assistant Coroner for** **East Sussex**