Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Chief Executive Officer** **East Suffolk Council** **Station Road** **Melton** **Woodbridge** **IP12 1RT**
1	**CORONER** I am Nigel PARSLEY, HM 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 20 July 2022 I commenced an investigation into the death of: **John Thomas GRAY** The investigation concluded at the end of the inquest on 10 January 2024. The conclusion of the inquest was: **Accidental Death** The medical cause of death was confirmed as: **1a Pneumonia** **1b Fractured Ribs, Splenic and Renal Haematoma** **1c Trauma** **II Frailty, Asthma, Obstructive Sleep Apnoea, Stroke**
4	**CIRCUMSTANCES OF THE DEATH** John Gray died at Ipswich Hospital, Heath Road, Ipswich in Suffolk, on the 13th July 2022. John had been admitted to the Ipswich Hospital on the 9th July 2022, after his mobility scooter drove off the promenade at Felixstowe beach, after John had fallen asleep. At the location this occurred, there was no barrier in place to prevent a fall, and the drop was one of several feet. In his fall, John suffered multiple rib fractures leading to respiratory failure. John's condition continued to deteriorate following his admission, and he passed away at 04:30, on the 13th July 2022.

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: Evidence was heard that the height of drop from the edge of the promenade to the sand at the location John fell, whilst on his mobility scooter, was approximately 5 feet. The court was told that, at a number of locations, the height from the edge of the promenade to the sand was prone to change, and a system was in place to monitor this. It was however, acknowledged, that unusual high tide conditions, and/or weather activity could significantly change the drop height in a short period of time. Evidence heard that at high-risk locations, such as areas with persistent long drops, drops onto concrete, or drops onto rock sea defences, permanent barriers were installed. In other areas signage and/or painted markings were used to highlight the risks of a potential fall. It was acknowledged that individuals on mobility scooters were known to regularly access and use the promenade. Due to the demographics of the local area it was acknowledged that the use of mobility scooters on the promenade may increase in the future. Evidence was also heard from a mobility scooter supplier and engineer, who explained that falling asleep on a mobility scooter was not uncommon, and happened more frequently than the general public might think. The supplier explained that this often led to accidents, leading to damage to the mobility scooters, which required repair. I am therefore concerned that falls from the promenade onto the beach, in areas where there is no barrier, would occur again in similar circumstances, as the current signage and markings provide no warning to an individual asleep on their mobility scooter. If this were to occur (as in this case) in an area where the height of drop from the edge of the promenade to the sand was greater than normally expected, I am concerned this would lead to future loss of life.
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 any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by March 15, 2024. I, the Senior 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: **1. John's next of kin** **2. East Mobility Services (EA) Ltd** **3. Motability Operations Limited**

	4. Howard House Surgery 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Dated: 19/01/2024**  **Nigel PARSLEY** **HM Senior Coroner for** **Suffolk**