




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: Greek authorities via FCDO.
1	CORONER I am Ms Jacqueline Devonish, Senior Coroner for the coroner area of Cheshire
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 05 January 2024 I commenced an investigation into the death of Andrew James STORY aged 56. The investigation concluded at the end of the inquest on 26 June 2024. The conclusion of the inquest was that: Accident
4	CIRCUMSTANCES OF THE DEATH On 12 October 2023, 56 year old Andrew Story went for a swim in the sea in Rethymno whilst on holiday in Crete. He was only gone for a few minutes when a bystander was seen undertaking CPR on him, on the beach. A post mortem conducted in Greece offered a cause of death as drowning in sea water. A UK post mortem identified drowning but also left ventricular hypertrophy. Mr Story was taken away by ambulance but was sadly confirmed deceased thereafter.
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: 'It was understood that the Greek Coroner had informed bereaved family members that the sea was particularly rough in Rethymno, Crete and had no lifeguards on duty between 31 August and the end of the summer season. This coincided with tourist season making the use of that beach and sea for swimming generally, and particularly unsafe in the absence of red warning markers, signs or flags
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 August 26, 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 I have also sent it to 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: 03/07/2024  Jacqueline DEVONISH Senior Coroner for Cheshire