Catherine Sarah Forbes

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted], General Manager, The Yacht Harbour Association Ltd
1	**CORONER** I am Mr D M Salter, HM Senior Coroner for Oxfordshire.
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 10 April 2024 at Oxfordshire Coroner's Court I conducted the inquest into the tragic death of Catherine Forbes, aged 57, at Thames and Kennet Marina, Caversham. She was a resident in her boat at the marina but drowned after falling into the marina late on 31 March 2023. She was discovered the following morning. A subsequent post mortem examination confirmed that the cause of death was drowning. I returned a conclusion of 'Accident' and attach a copy of the Record of Inquest for your information. I announced at inquest that I would consider making a Regulation 28 Reports for the Prevention of Future Deaths following some further enquiries and submissions. You will no doubt recall that I wrote to you on 25 April 2024 and you responded on 28 May 2024. I consider that I am now under a duty to make this report. I heard oral evidence at the inquest from the Marina Manager for Tingdene Ltd. I was provided with documentation prior to inquest and, importantly, further documents afterwards in respect safety improvements relating to ladders and risk assessments. I also heard evidence in relation to the YHA and the fact that Tingdene held your Gold Anchor Award at this marina.
4	**CIRCUMSTANCES OF THE DEATH** The brief circumstances are set out in the attached Record of Inquest but I also attach the Final Police Report of [redacted] dated 4 December 2023. The drowning was unwitnessed but Ms Forbes was said to be a strong swimmer and there is clear evidence that she swam to a nearby ladder and tried to use it to climb out. She appears to have thrown her handbag from the water onto the pontoon. There were marks on the toes of her boots indicative of her trying to get out. This particular ladder was 1.5m in length with 3 rungs in the water but the

	bottom rung extended no more than 600mm beneath the surface of the water. It would have required Ms Forbes to raise her legs up high and have the necessary strength to pull herself up. It appears that, sadly, she was unable to do so before succumbing to the cold and drowning.
5	**CORONER'S CONCERNS** **During the course of the Inquest the evidence revealed matters giving rise to concerns. 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 make this report to you.** **The MATTERS OF CONCERN are in relation to the following:** I am mindful that safety improvements have been made at the Thames and Kennet Marina, specifically in relation to risk assessment and ladders having been upgraded to 2m in length with a minimum of 1m beneath the water. This is welcomed, not least because Catherine Forbes was the third person to drown in similar circumstances at the marina since 2016. I have continuing industry wide concerns which, I believe, your organisation is in a position to take account of and review. I note from your response dated 28 May 2024 that British Marine and YHA are keen to ensure that marinas are as safe as possible. The particular concern is in relation to persons falling into the marina, on their own and unwitnessed, and what measures are in place to enable them to get out or raise the alarm. Perhaps the main issue relates to sufficiently designed ladders, in terms of length and grip, but also their number, placement and visibility from the water at day or night (flags, fluorescent signage, lighting for example). It is not for me to make recommendations and I am not an expert of course on marina safety but it is my duty to raise concerns that reflect the evidence heard at inquest and the issues helpfully raised by Ms Forbes family. With this in mind, I enquire if there are flotation devices or small platforms which sit on the surface of the water which a person could access more easily? I also enquire if there are alarm systems that exist or could be considered which can be activated from the water. I appreciate of course they would need to be non-electrical or non-battery or fully waterproof. Further, with regard to the Gold Anchor Award, it appears that the important issue of safety is not one of the key attributes or evaluation categories. Thames and Kennet held the top 5 Gold Anchors at the time of Ms Forbes death but were not fully compliant with the TYHA 2013 Code of Practice in relation to the length of all ladders. I note the 2013 Code is being reviewed from June 2024 and I enquire if the concerns raised in this report can be taken into account, in conjunction with designers and suppliers who the TYHA consult with. I can advise that I will be supplying a copy of this report to the HSE and also the organisation with oversight of District Council's who often have responsibility for health and safety enforcement of marinas instead of the HSE.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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. I may extend the period on request. 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 confirm that a copy of this report and your response will be sent to Ms Forbes family. 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	**Signed** **Date** 14th November 2024  **Mr D.M. Salter** **HM Senior Coroner for Oxfordshire**