REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

- 1. Avon & Somerset Constabulary
- 2. Sainsburys PLC

1 CORONER

I am Maria Voisin, Senior Coroner, for the Area of Avon

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 31st January 2014 I commenced an investigation into the death of **Christopher David TAYLOR**, Aged **21**. The investigation concluded at the end of the inquest on 16th January 2015. The conclusion of the inquest was as follows

Medical Cause of Death

1a) Drowning

Conclusion

Christopher Taylor died when he fell into the River Avon in Bath; he was unable to find a way out himself and despite the efforts of the emergency services at the scene he was not able to be rescued by them

4 CIRCUMSTANCES OF THE DEATH

Christopher was a student at Bath University and on 22nd January he had been out drinking with friends. The evidence of a witness was that he heard Christopher calling for help from the river and he dialed 999 for the emergency services. That call was created by the call handler at Avon and Somerset Constabulary at 04:10 hrs. on 23rd January 2014.

That call required an immediate response so it was graded as immediate at 04:12 hrs The call handler completed the call and transferred it to dispatch at 04:14 hrs.

A subsequent witness indicated that immediate incidents are clearly indicated on the screen with a red flashing outline. This immediate incident would have been flashing in the supervisors screen from 04:12 hrs. and in the dispatchers screen from 04:14 hrs.

The Force Service Centre Supervisor called to ensure that the dispatch centre were aware of the incident as the call had not been accepted. This telephone call resulted in the call being accepted at 04:19 hrs with officers being dispatched at 04:20 hrs. There is no explanation for what happened during that 5 minute period.

Officers were at the scene at 04:23 hrs. when Christopher was still alive.

At 04:36 hrs. Christopher went under the water and all attempts to rescue him were unsuccessful.

During the inquest it became clear that there were issues in relation to fencing along the River Avon and the fact that all life buoy ring stations that were checked had no life buoy ring present as they had been vandalised.

I heard that Bath and North East Somerset together with the Fire Service have been working on developing a vandal proof life buoy station. I also heard that the length of the River Avon is not owned in its entirety by Bath and North East Somerset and indeed the banks are owned by many different people and organisations. The area of the river bank where Christopher fell in is owned by Sainsburys and this is considered to be in a high risk area. **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. -1. In this particular case it appears that the team in dispatch were not aware of the immediate incident which resulted in a delay in it being actioned by them. Staff need to be able to see at all times a screen which displays incoming incidents for them to be able to action in an appropriate manner. 2. I appreciate that Sainsburys were not represented at the inquest and I do not have any evidence from them in relation to their plans for the bank next to the River Avon in Bath however I would ask that they consider their responsibility as land owner along this stretch of river in question which falls within the high risk area. Specifically I would ask that they liaise with Bath and North East Somerset Local Authority in relation to potentially the provision of a vandal proof life buoy station along that stretch of river. **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. YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday 10th April 2015. 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. **COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons - the family, Avon Fire & Rescue Service and the Bath and North East Somerset Local Authority

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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.

M. E. Voisin 13.2.15 9