REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Suffolk County Council Highways Department

1 CORONER

I am Nigel Parsley Assistant 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 the 30th November 2015 I commenced an investigation into the death of Archie James Hall, aged 20. The investigation concluded at the end of the inquest on the 7th April 2016. The conclusion of the inquest was misadventure with the medical cause of death recorded as being 1(a) aortic transection, 1(b) fall from height.

4 CIRCUMSTANCES OF THE DEATH

Mr Hall was a student at Lincoln University who found himself overwhelmed by his studies and with the agreement of his family returned to his Ipswich home on the 24th November 2015

Shortly after arriving home Mr Hall unexpectedly left again in the family car. His family were concerned and started to look for him. The car was subsequently found parked at The Strand, Ipswich beneath the Orwell Bridge. Mr Hall was found on the ground beneath the bridge and regrettably efforts to resuscitate him by both family and paramedics who attended the scene were unsuccessful.

Mr Hall was pronounced dead at 21:10 hours on Tuesday 24th November 2015.

5 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 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. -

The Orwell Bridge is a well known very high structure in Suffolk that can be easily accessed on foot. There are a number of locations that provide parking within close walking distance.

Once on the bridge there is a pedestrian walkway on both sides which allows full access to its entire length. A concrete wall runs the length of the bridge on the river side of each walk way. A vehicle crash barrier separates each walkway from the carriageway.

The bridge wall is between waist and low chest height for an adult and is approximately 30-40 cm in width. As such it is easy to straddle for the majority of reasonable fit adults or young persons.

This relatively low concrete wall is the only barrier preventing a fall from the bridge. There is nothing in place that would make it either physically difficult or provide a

deterrent against climbing onto the bridge wall.

Further, the river side of the bridge walls are bare vertical concrete. As such should someone who had straddled the wall subsequently slip, there is nothing on the structure that would provide a hand or foothold allowing them the opportunity to climb back onto the bridge.

This is by no means an isolated incident and I am aware that further inquests are to be held shortly in relation to other deaths resulting from falls from Orwell Bridge.

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. Given the issues identified here following this very sad death, I would request that consideration is given to examining the structure described above and seeing what steps can be taken to make it more difficult for the wall to be climbed and for similar tragedies to occur.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by the 7th of July 2016. 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:

Mr Hall's family

I am also under a duty to send the Chief Coroner a copy of your response. Similarly, you are 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.

9 Mr N Parsley 12-5-16