VERONICA HAMILTON-DEELEY DL, LL.B. Her Majesty's Senior Coroner for the City of Brighton & Hove THE CORONER'S OFFICE WOODVALE, LEWES ROAD BRIGHTON BN2 3QB

Assistant Coroners CATHARINE PALMER LL.B (HONS) GILVA D.J.TISSHAW, BA(LAW)HONS Telephone: Brighton (01273) 292046 Fax: Brighton (01273) 292047

CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT IS BEING SENT TO:
	1. Chief Inspector Andrew Bennett, Sussex Police
1	CORONER
	I am Gilva Dagmar Jane Tisshaw, Assistant Coroner, for the City of Brighton and Hove
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 23 rd October 2018 an investigation into the death of David DOOLEY was commenced. The investigation concluded at the end of the inquest on 19 th March 2019. The conclusion of the inquest was ACCIDENTAL DEATH as set out on the attached document.
4	CIRCUMSTANCES OF THE DEATH See Record of Inquest
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 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) The exact location of the life lines on Brighton seafront were not known to the Police officers who attended the scene of the incident. Mr Dooley's friend informed security at the local night club that he believed that Mr Dooley was in the sea and the police officers attended very quickly. The location of the life

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	having taken drugs. (4) It should be noted that I have spoken with a representative of Sussex Police and they have looked closely at this incident on the 13 th October 2018 and have made significant changes in their water safety training. In addition, they are considering this information being included on the AX Mapping System. (5) As regards increasing public awareness as to the dangers of swimming whilst under the influence of alcohol or drugs and in adverse weather conditions, liaison should be undertaken with representatives of night club security and representatives of the Seafront Operations Manager's Office and the Local Sea Safety Forum who have high levels of experience in this area.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you AND your organisation have the power to take such action.
7	You are under a duty to respond to this report within 56 days of the date of this report, namely by 1 st June 2019. 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	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons 1.

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	I have also sent it to:- 1. Seafront Office Manager, Brighton Who may find it useful or of interest.
	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.
9	Date: 10 th April 2019 SIGNED BY: Assistant Coroner Brighton and Hove