

## IAN MICHAEL ARROW Senior Coroner for Plymouth, Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: The Highways Department, Cornwall Council, County Hall, Treyew Road, Truro, Cornwall TR1 3AY The Highways Department, Devon County Council, Topsham Road, Exeter, Devon EX2 4 QD
	Tamar Bridge & Torpoint Ferry joint Committee, Tamar Bridge Office, Pemros Road, St. Budeaux, Plymouth PL5 1LP
1	CORONER
	I am IAN MICHAEL ARROW, Senior Coroner for Plymouth, Torbay and South Devon
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. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a>
3	INVESTIGATION and INQUEST
	On 08/07/2016 I commenced an investigation into the death of Charles Edward Pitcher, 18. The investigation concluded at the end of the inquest on 19 September 2016. The conclusion of the inquest was INTENTIONALLY TOOK HIS OWN LIFE On 5 July 2016 the deceased jumped over the walking barrier of the Tamar Bridge and landed in Wolseley Road, Plymouth. He suffered fatal injuries. Multiple Traumatic Injuries consistent with a fall from height
4	CIRCUMSTANCES OF THE DEATH On 5 July 2016, the deceased jumped over the walkway barrier of the Tamar Bridge and landed in Wolseley Road, Plymouth. He suffered fatal injuries. I found the deceased intentionally took his own life
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
	At the Inquest I received information from Detective Constable who informed me there have been 11 persons who had jumped from the bridge in the last 10 years. He formed the view that it was all too easy to jump the barrier. He also made the observation there was a risk to persons in Wolseley Road arising from people crossing the walkway barrier at that point. He made the observation that on other significant bridges and he gave as an example the Humber Bridge, the operators have established precautions and set up appropriate notices.
	I would ask you please to review the procedures and measures you have in place to reduce the likelihood of a suicide being completed from the Tamar Bridge.

6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you The Highways Departments of both Cornwall and Devon together with the Tamar Bridge Joint Committee, have the power to take such action and review the operation of the Tamar Bridge so as to minimise the risk of suicides being completed from the Bridge.
7	YOUR RESPONSE
	You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 November 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 - the family of the deceased.
	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	Dated 19 September 2016
	Signature Senior Coroner for Plymouth, Torbay and South Devon