REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Peel Holdings; 2. Trafford County Council; 3. Canals and Waterways Agency;
1	**CORONER** I am Rachel Galloway, assistant coroner, for the coroner area of South Manchester
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 the12th October 2017 an inquest was opened into the death of Casper Blackburn. The evidence was heard at inquest o the 23rd March 2018 and my conclusions were given on the 29th October 2018. The conclusion left was a narrative conclusion: "Casper died from the recognised complications of accidentally entering the canal contributed to by very poor lighting". The medical cause of death was: 1a drowning.
4	**CIRCUMSTANCES OF THE DEATH** Casper Blackburn died in the early hours of the morning on the 1st October 2017 after he entered the Bridgewater canal in the vicinity of St Paul's Church on Springfield lane, Sale in unclear circumstances. It is likely that very poor lighting in the area and a degree of intoxication on Casper's part contributed to his death.
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. – The lighting in the area where Casper likely accidentally entered the canal was extremely poor. There is no CCTV in the area and therefore what precisely happened on the morning of Casper's death is unclear. Evidence was heard that police attended the scene at night on a date following Casper's death. The area was so dark that it was very difficult to discern the canal from the grass verge or the path. I am concerned that

	future deaths might occur if action is not taken to address this.
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, namely by 29th May 2018. 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 the family of Casper Blackburn, 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	Rachel Galloway HM Assistant Coroner 03/04/2018