	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sir Philip Dilley, Chief Executive, Environment Agency Headquarters, Bristol**
1	**CORONER** I am Mr Andrew Haigh senior coroner for the coroner area of Staffordshire South
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 26 August 2014 I commenced an investigation into the death of Kai Lambe aged 9 years. The investigation concluded at the end of the inquest on 1 October 2014. The conclusion of the inquest was Accidental death with Kai having died from the effects of drowning.
4	**CIRCUMSTANCES OF THE DEATH** Kai Lambe was certified dead at Queen's Hospital Burton at 22.38 on 22nd August 2014 from the effects of drowning. Earlier that day he had gone to the Rover Dove at Tutbury and had gone down a salmon chute. He could not swim very well and sank under the water.
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 was told that children have played at this location for many years. Is does however appear that travelling along the weir and going down the salmon chute is extremely risky. I believe that you have some responsibility for the site and that there is one small warning sign. Although you may already be aware of the circumstances of this tragic death and are taking action I write to you know to ask you to consider if safety measures including signage at the scene should be improved. If you feel that this is not your responsibility could you please let me know who is responsible for the location?
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your

	organisation 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 1 December 2014. 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: [redacted] (Parents of Kai), Dr R Hunter Senior Coroner for Derbyshire and to the LOCAL SAFEGUARDING BOARDS for Staffordshire and Derbyshire. 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	**6 October 2014** Andrew A Haigh HM Senior Coroner Staffordshire (South)