KALLY CHEEMA
SENIOR CORONER

County of Cumbria

Fairfield
Station Rd
Cockermouth, CA13 9PT

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: [redacted] **Cumbria County Council**
1	**CORONER** **I am Miss Kirsty Gomersal Area Coroner for County of Cumbria**
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: https://www.legislation.gov.uk/ukpga/2009/25/contents http://www.legislation.gov.uk/uksi/2013/1629/contents
3	**INVESTIGATION and INQUEST** On 10 September 2021, an investigation was commenced into the death of Mr Peter John MOORBY ("Peter"). Peter's inquest was opened on 22 September 2021 and concluded on 8 February 2022. The medical cause of Peter's death was: 1a Head Injuries The determination was: *Mr Peter John Moorby died at the Royal Lancaster Infirmary on 5 September 2021. Mr Moorby had been seen to leave a friend's house at about 22:30 on 4 September 2021. At approximately 01:00 on 5 September 2021, Mr Moorby was located in a beck off Millstream Court, Cark-in-Cartmel, with a severe head injury. His entry into the water was unwitnessed. Mr Moorby was found at the bottom of an 8-10 foot drop having fallen over a knee high wall in an unlit area. Mr Moorby was treated at the scene and during transfer to the Royal Lancaster Infirmary. Treatment continued there but Mr Moorby died at 05:50. Post-mortem blood evidence alcohol* [redacted] The conclusion of the inquest was: Accidental Death.

4	**CIRCUMSTANCES OF THE DEATH** On the evening of 4-5 September 2021, Peter had been visiting a friend's house on [redacted]. When he left his friend's house, Peter was well although under the influence of alcohol. On 5 September 2021 at approximately 01:00, residents of [redacted] heard someone in distress. Mr Moorby was found in the beck which is on the opposite side of a low wall that runs alongside the access road to [redacted]. Peter had a severe head injury and was partly in the water. Peter's entry point into the beck was over the low wall which is less than knee height. Peter had fallen approximately 8 – 10 feet into the beck. Evidence was heard from a number of emergency services personnel about the difficulties in extracting Peter from the location. Peter subsequently died from the injuries sustained in the fall. Evidence was given at the inquest that there is danger during the hours of darkness as the area is unlit, the wall is so low and there are no barriers to prevent anyone falling.
5	**<u>CORONER'S CONCERNS</u>** 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: I am concerned about the risk of future deaths posed by the low wall. The wall is less than knee height and offers no real protection from the significant drop of 8-10 feet into the River Eea which has a rock-strewn riverbed. The area is also unlit at night.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that you have the power to take such action: [redacted]. I believe [redacted] to be the owner of the freehold of the land on which the access road and low wall is situated. AND I understand that maintenance of the access road is shared equally between those properties abutting the access road. As the wall appears to retain the road, I believe that the low wall forms part of the access road. This Notice is therefore served on those properties adjoining the access road: [redacted]. The Land Registry details indicate they are the owner of a property adjacent to the access road. [redacted] Land Registry details indicate he is the owner of land adjacent to the access road. [redacted] The Land Registry details indicate they are the owner of a property adjacent to the access road. [redacted]. The Land Registry details indicate they are the owner of a property adjacent to the access road.

	AND Cumbria County Council of Cumbria House, 117 Botchergate, Carlisle, CA1 1RD as Street Works Authority under the Highways Act 1980. This Report has been delayed due to the difficulties in ascertaining who is responsible for the access road / low wall.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **18 August 2022.** 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], Peter's mother. 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	23 June 2022  Miss Kirsty J Gomersal HM Area Coroner County of Cumbria