Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an Inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Executive** **Wigan Metropolitan Borough Council**
1	**CORONER** I am John Stanley POLLARD, Assistant Coroner for the Coroner area of Manchester West
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 10 September 2024 I commenced an Investigation into the death of Alex Edward CROOK aged 15. The Investigation concluded at the end of the Inquest on 29 January 2025. The conclusion of the Inquest was: Accident due to drowning
4	**CIRCUMSTANCES OF THE DEATH** On the 07 September 2024 Alex Edward Crook went to "Scotsmans Flash" with his friends. They were playing in the edge of the lake when he went out of his depth and drowned. He was taken to Royal Albert Edward Infirmary, Wigan where he was finally pronounced dead.
5	**CORONER'S CONCERNS** During the course of the Investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) [1] He did not have statutory swimming lessons at key stage 1 or 2 and I am informed that three schools in Wigan area still in breach of statutory duty to deliver such lessons. [2] I am informed that signs have been erected as recently as 29 January 2025 at Scotsmans Flash yet these do not contain the words "no unauthorised swimming". It was agreed in evidence that if such signs were erected expeditiously close to the obvious entry points to the water, it might deter such use. [3] It was established in evidence that throw lines are the most effective life-saving equipment. It was noted that the proposal is to locate these away from obvious entry points. This would seem to be likely to make them less effective than if they were sited at the more obvious entry points. The need for such equipment, as with the signage, is urgent.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 27 March 2025. 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] I have also sent it to Bolton, Salford and Wigan Child Death Overview Panel who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 30/01/2025** **John Stanley POLLARD** **Assistant Coroner for** **Manchester West**