**Regulation 28: REPORT TO PREVENT FUTURE DEATHS**

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**West Sussex County Council** |
| **1** | **CORONER**<br><br>I am Joanne ANDREWS, Area Coroner for the coroner area of West Sussex, Brighton and Hove |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 02 November 2024 I commenced an investigation into the death of Doreen TURNER aged 91. The investigation concluded at the end of the inquest on 30 April 2025. The conclusion of the inquest was that:<br><br>Doreen Turner died on 1 November 2024 having been found in her car in the canal at the of South Bank, Chichester, West Sussex. She died as a result of drowning having entered the water. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>Mrs Turner drove her car into the canal at the end of Canal Bank, Chichester, West Sussex on 1 November 2024 at around 2130hrs. It is not clear why the car ended up in the canal but there was no evidence of mechanical failure or impairment of Mrs Turner being contributory to events. |
| **5** | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows:<br><br>The inquest was told that South Bank is a residential cul de sac. At the end of the road, there is a footpath which is perpendicular to the road which also runs alongside the canal. The end of the road has kerbing, a 5ft foot grass section and then the canal. The inquest heard that the kerbing is less than standard height and there are no |

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| | devices present to prevent a vehicle which passes over the kerbstones from entering the canal. The evidence was that Mrs Turner was the second driver to have entered the canal in a vehicle in the last 5 years at that location. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. |
| **7** | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report,<br>namely by June 25, 2025. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>**Family of Mrs Turner**<br><br>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.<br><br>I may also send a copy of your response to any person who I believe may find it useful or of interest.<br><br>The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who he believes may find it useful or of interest.<br><br>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: 30/04/2025<br><br>J. Andrews<br>Joanne ANDREWS<br>Area Coroner for<br>West Sussex, Brighton and Hove |