REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Mrs Joanne Lees, the Area Coroner for The Black Country Jurisdiction.
2.	**DATE OF REPORT** 21 August 2026
3.	**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.	**THIS REPORT IS BEING SENT TO** 1. **Walsall Council** C/O The Chief Executive, Walsall Council, Civic Centre, Darwall Street, Walsall. WS1 1TP 2. **The Canal & River Trust** National Waterways Museum, Ellesmere Port, South Pier Road, Ellesmere Port, Cheshire, CH65 4FW You are under a duty to respond to this report within 56 days of the date of this report, namely by **16 October 2026**. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

	The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	**SUMMARY OF CORONER'S CONCERN** I am concerned that there is an ongoing safety concern involving people accidentally falling into the canal basin [redacted]
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 8 May 2026 I commenced an investigation into the death of Ms Jody BROWN who died on 3 May 2026 at the Canal Basin, [redacted] **The medical cause of death was** Cause of death 1a Cardiorespiratory Arrest Cause of death 1b Drowning Cause of death 1c Extreme Alcohol Intoxication **How, when and where** In the early hours of 3 May 2026, Ms Jody Brown was found deceased in the Canal Basin,[redacted]. She died as a result of drowning. CCTV showed Ms Brown leaving a hotel alone and walking towards the water's edge before entering the canal. It is likely that she was heavily intoxicated by alcohol at the time. **Conclusion at inquest** Accident
8.	**CIRCUMSTANCES OF DEATH** On 3 May 2026, Jody Brown, aged 38, drowned after entering the canal basin [redacted] During the evening she had been visiting at the Premier Inn and had consumed alcohol and was described as heavily intoxicated. It was a wet evening. CCTV footage showed her leaving the hotel alone at approximately 01:10 hours carrying a bag and drink, walking unsteadily whilst looking at her mobile phone. She proceeded towards the canal basin and walked from the paved area straight off the footpath into the water. Witnesses heard calls for help and assisted in recovering her from the canal, but resuscitation attempts were unsuccessful and she was confirmed as deceased at the scene.
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: 1. The lighting around the canal basin, footpaths and nearby walkways appears inadequate, resulting in poor visibility during hours of darkness. 2. Signage warning members of the public of the presence and proximity of the canal appears absent or insufficient. 3. There are no safety railings or other physical barriers around the canal basin even allowing for access requirements. 4. There appears to be an absence of public rescue equipment, such as life rings, throw lines or rescue poles. 5. There appears to be an absence of ladders or other readily accessible means of self-rescue for persons who enter the water. 6. The presence of algae on the surface of the canal may make it difficult to distinguish the water's edge from the adjacent pedestrian area, creating the appearance of a continuation of the footpath and/or a grassed surface area. 7. Information came to light during the investigation that the accumulation of algae had previously been identified as an issue in 2019 and that similar non-fatal incidents occurred at this location in 2019 and 2022, raising a concern that the risks identified above may be ongoing. 8. Evidence received during the investigation includes reports of other occasions on which individuals have inadvertently walked from the paved area into the canal basin. 9. Taken together, these matters raise concern that there remains a risk of future deaths at this location, particularly during hours of darkness and/or in poor weather conditions.
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to the family of the deceased I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
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