REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used after an inquest.

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Head of Legal Sibelco UK Ltd Brookside Hall Congleton Road Sandbach Cheshire WF11 4TF

Borough Council of King's Lynn King's Court Chapel Street King's Lynn PE30 1EX

Principal Planner
Monitoring and Control (Planning Services)
Public Protection
Environment, Transport and Development
Norfolk County Council
County Hall
Martineau Lane
Norwich
NR1 2SG

Temporary Superintendent Norfolk Police The Police Station St James Street King's Lynn PE30 1ES

1 CORONER

I am JACQUELINE LAKE, Senior Coroner, for the Coroner Area of NORFOLK

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 22 July 2013 I commenced an investigation into the death of RYAN JAMES PETTENGELL, then aged 41 years. The investigation concluded at the end of the inquest on 25 February 2014. The conclusion of the inquest was Accidental Death, the medical cause of death being Drowning.

4 CIRCUMSTANCES OF THE DEATH

- (1) On 16 July 2013 Mr Pettengell went with friends to a disused quarry at Bawsey, King's Lynn.
- (2) The quarry is a popular recreation area which includes various lakes.
- (3) There is an Agreement in place that the area will be accessible to the public for recreational purposes. Swimming in the lakes is prohibited.
- (4) Mr Pettengell entered one of the lakes and attempted to swim to a nearby island.
- (5) Mr Pettengell got into trouble and drowned.

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. -

- (1) The site has been officially closed since this incident (and another drowning on the same day) whilst meetings are ongoing with the community as to the best way to provide recreational facilities to the public whilst having regard to the public's safety;
- (2) Recommendations were put forward by the King's Lynn and West Norfolk Council on 20 August 2013 with regard to increasing safety at the site;
- (3) Six months later, no action has been taken with regard to increasing safety at the site.
- (4) Evidence was given at the inquest that the public are still gaining access to the site:
- (5)There is no signage around the lake prohibiting swimming in the area where Mr Pettengell entered the water;
- (6) Some of the existing signage is damaged and/or has been removed.

6 ACTION SHOULD BE TAKEN

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

You are under a duty to respond to this report within 56 days of the date of this report, namely by 30 April 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.

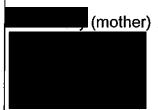
8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-

West Norfolk and King's Lynn Borough Council and Sibelco UK Ltd.

I have also sent it to Norfolk County Council and Norfolk Constabulary who may find it useful or of interest.

Derek Winter (Archivist)
HM Coroner for the City of Sunderland
Civic Centre
Burdon Road
Sunderland
SR2 7DN



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 4 March 2014

