	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **East Staffordshire Borough Council**
1	**CORONER** I am Mr Andrew Haigh Senior Coroner for the Coroner area of Staffordshire South.
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 the 10 May 2013 I commenced an investigation into the death of Joseph Drew Whiteside aged 20. The investigation concluded at the end of the inquest on the 11 December 2013. The conclusion of the inquest was accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Joseph Whiteside's body was found in the River Trent in Burton on 10th May 2013. It is likely that late on the 2nd May 2013 in an intoxicated state he had fallen into the river, had been unable to extricate himself and had 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:– Since I have been a Coroner in this jurisdiction I have held Inquests into the deaths of a number of young men who in an intoxicated state have fallen into the River Trent at Burton and drowned. I fully understand that at Burton the river does split and there are numerous access points to the water. I am told that in one or two places there are life buoys and I now wonder that if in the main access points there should be further safety measures such as fencing and/or warning signs. I should be grateful if you could carry out a review to see if any further such action should be taken.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 10 February 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: [redacted] – Joseph's mother and [redacted] Joseph's father. I have also sent it to Mr Derek Winter – Coroner for Sunderland, Dr Robert Hunter – Coroner for Derbyshire who may find it useful or of interest. 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	**16 December 2013** Andrew A Haigh HM Senior Coroner Staffordshire (South)