	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mike Creedon, Chief Constable, Derbyshire Police**
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 26 August 2014 I commenced an investigation into the death of Kai Lambe aged 9 years. The investigation concluded at the end of the inquest on 1 October 2014. The conclusion of the inquest was Accidental death with Kai having died from the effects of drowning.
4	**CIRCUMSTANCES OF THE DEATH** Kai Lambe was certified dead at Queen's Hospital Burton at 22.38 on 22nd August 2014 from the effects of drowning. Earlier that day he had gone to the Rover Dove at Tutbury and had gone down a salmon chute. He could not swim very well and sank under the water.
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 **MATTER OF CONCERN** is as follows. – At the inquest I heard helpful evidence from Inspector [redacted] from your force. The incident which led to death took place in the River Dove which borders Staffordshire and Derbyshire. Because of local masts the initial 999 call went to Derbyshire. Derbyshire determined that the incident was in Staffordshire (emulating from the Staffordshire side of the River) and transferred the emergency call to Staffordshire. Staffordshire Officers then responded. Inspector Abbott indicated that this was in accordance with protocol although protocol does not necessarily have to be followed. There was a difference of 5 minutes between the time that the call was received by Derbyshire and the Staffordshire log commencing. In a case of a drowning child, 5 minutes can be very significant. I wonder if there is a training need for control room operators in Derbyshire to be aware to dispatch immediately Derbyshire Officers in urgent situations occurring on or close to the border between the 2 counties.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 1 December 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 Dr R Hunter HM Senior Coroner for Derbyshire, [redacted] (Parents of Kai) and to the LOCAL SAFEGUARDING BOARDS of Staffordshire and Derbyshire. 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	**6 October 2014** Andrew A Haigh HM Senior Coroner Staffordshire (South)