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:** **1. Kevin Morrell, Head of Business Continuity, Northumbria Water** **2.** **3.**
1	**CORONER** I am Eric Armstrong, senior coroner, for the coroner area of Northumberland (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 15th May 2014 I commenced an investigation into the death of Darren William Thorpe Age 41: Gavin Thomas Bradley Age 36: and Mark Thorpe Age 39. The investigation concluded at the end of the inquest on 25th September 2014. The conclusion of the inquest was That each died of drowning and each was an Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** On the morning of the 11th May 2014 the three men entered the river Tyne on a "sit on " Kayak, in the Hexham area. An alarm was raised by a family member when the men failed to return or to contact any of their families. A Police search, assisted by an RAF helicopter and other organisations located the bodies of all three men at points downstream of the Riding Mill weir. One Kayak was located at the weir and other items were recovered downstream of the weir.
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) Evidence was given that in other countries within Europe, weirs are constructed with a specific channel to allow the passage of canoes and kayaks without encountering the tow back, or stopper, caused by the anti-scour sill at the foot of the weir. Would it be feasible to amend the design of the Riding Mill weir to incorporate such a channel? (2) Evidence was given that on a previous visit to the River Tyne the men had exercised due caution in negotiating the weir by alighting upriver of the weir. It was felt that the most likely interpretation of the known circumstances was that the kayakers had been unable to exit the river because of the flow of water. Would it be feasible to construct a suitable landing area, accompanied by

	appropriately worded warnings, sufficiently far upriver to enable an exit from the river even at the time of a heavy flow of water? (3) Are there any other steps which might be taken to avoid a repetition of the circumstances surrounding these three deaths?
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 28th November 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]. 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	**2nd October 2014**