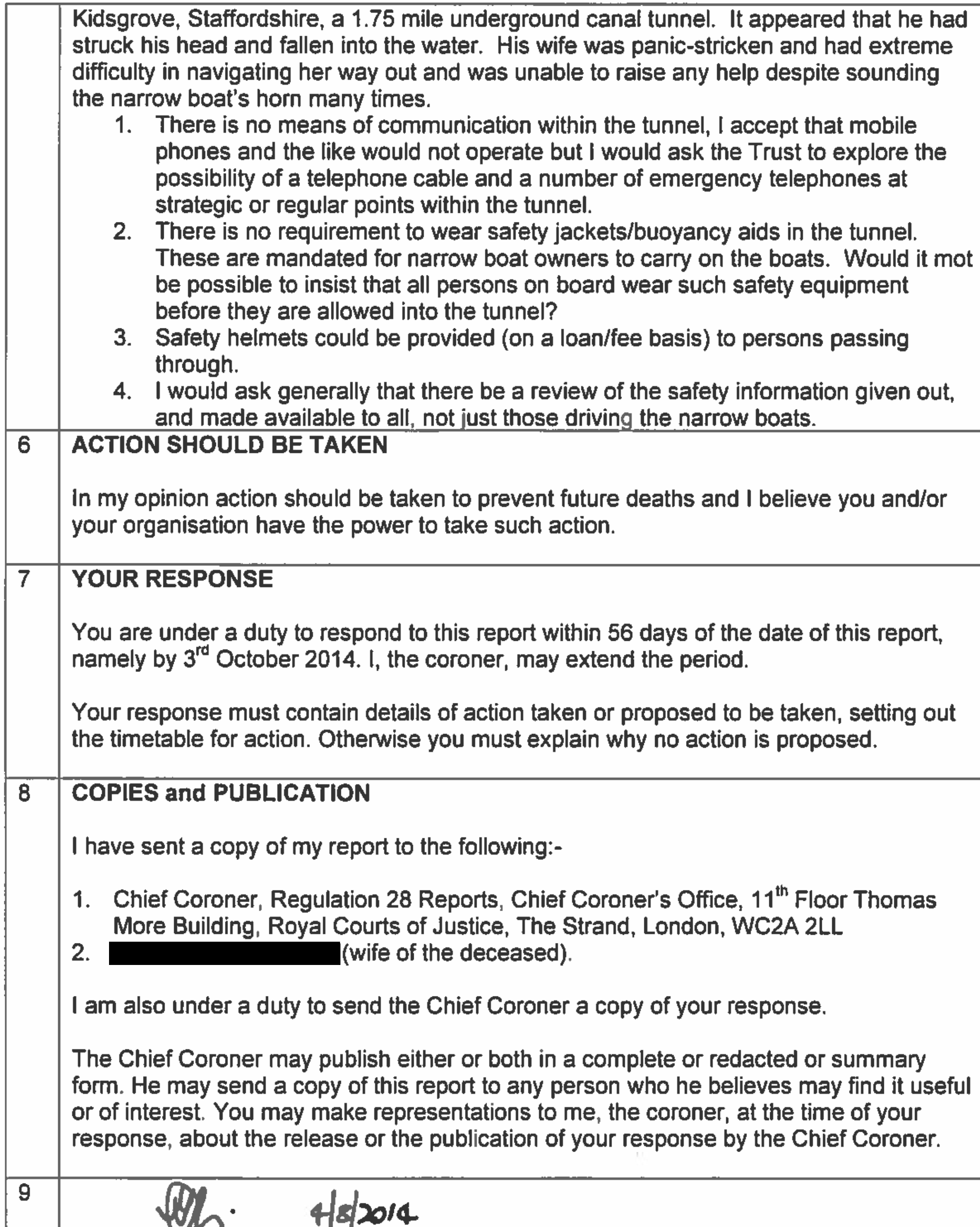
ANNEX A

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. [redacted] Safety Advisor North Canal & River Trust Red Bull Office Congleton Road South Church Lawton STOKE-ON-TRENT ST7 3AP
1	**CORONER** I am Ian S Smith, senior coroner, for the coroner area of Stoke-on-Trent and North Staffordshire.
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 28th May 2014 I commenced an investigation into the death of Michael Holgate aged 58 years. The investigation concluded at the end of the inquest on 29th July 2014. The conclusion of the inquest accidental death with the cause of death being given as 1a Death by immersion in water with broken neck.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 11.00am on 20 May 2014 the deceased, his wife and son were travelling on their narrow boat on the Trent and Mersey Canal in North Staffordshire when they arrived at the southern entrance to the Harecastle Tunnel, off Peacocks Hey, Talke, Stoke on Trent. The tunnel is approximately 2500 metres in length and has no lighting. The boat was logged as entering the tunnel with the deceased at the stern steering. As the boat was 1700 meters into the tunnel it collided with the side of the tunnel. The deceased appears to have fallen into the water but the precise circumstances were not clear as they were not witnessed. His wife and son were at the front of the boat. The deceased's body was discovered at 9.00pm that day inside the tunnel following a lengthy underwater search. A post mortem examination revealed the cause of death as death by immersion in water with a broken neck. Blood alcohol was negative.
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. – At the inquest I heard that the deceased had had an accident in Harcastle Tunnel,



	Kidsgrove, Staffordshire, a 1.75 mile underground canal tunnel. It appeared that he had struck his head and fallen into the water. His wife was panic-stricken and had extreme difficulty in navigating her way out and was unable to raise any help despite sounding the narrow boat's horn many times. 1. There is no means of communication within the tunnel, I accept that mobile phones and the like would not operate but I would ask the Trust to explore the possibility of a telephone cable and a number of emergency telephones at strategic or regular points within the tunnel. 2. There is no requirement to wear safety jackets/buoyancy aids in the tunnel. These are mandated for narrow boat owners to carry on the boats. Would it mot be possible to insist that all persons on board wear such safety equipment before they are allowed into the tunnel? 3. Safety helmets could be provided (on a loan/fee basis) to persons passing through. 4. I would ask generally that there be a review of the safety information given out, and made available to all, not just those driving the narrow boats.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 3rd October 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 following:- 1. Chief Coroner, Regulation 28 Reports, Chief Coroner's Office, 11th Floor Thomas More Building, Royal Courts of Justice, The Strand, London, WC2A 2LL 2. [redacted] (wife of the deceased). 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	[signature] 4/8/2014

H. M. CORONER