Richard G. Taylor
Senior Coroner for East Lancashire District

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Wales and West Utilities; Northern Gas Network; Scotia Gas Network; The Chair of the Association of Independent Gas Transporters.**
1	**CORONER** I am Richard G. Taylor, Senior Coroner for East Lancashire District
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 24/04/2014 I commenced an investigation into the death of Robbie Mark Williamson then aged 11. The investigation concluded at the end of the inquest on 04 March 2015. The conclusion of the inquest was Accidental death. On 22 April 2014 Robbie Mark Williamson fell from an exposed pipe into the canal. The medical cause of death being drowning.
4	**CIRCUMSTANCES OF THE DEATH** On the 22nd April 2014 Robbie was with two school friends when they dared each other to cross the canal by walking across an exposed cast iron gas pipe attached to the outside of a road bridge. The surface of the pipe was wet and slippery. There was no sign warning that there should be no access to the pipe. There were no obstacles to prevent access to the pipe. Robbie slipped whilst crossing and fell into the canal injuring himself on the canal bank as he did so. He was in the water a number of minutes before being pulled from the canal, where after he received medical treatment before being pronounced dead at Royal Blackburn Hospital the same day. [redacted] offered medical cause of death as; 1 (a) Drowning 2 Head injury National Grid accepted they were responsible for the pipe line. Evidence was heard that they control approximately a quarter of pipelines countrywide. Their own database had shown that this pipe was under the pavement. Since Robbie's death they have made the pipe safe and also commenced an investigation into the safety of the piping they control.
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) There may be exposed raised pipework for which you are responsible, either attached to bridges or otherwise, that is accessible to members of the public.

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6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 12 March 2015. 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: 1. [redacted] (Robbie's Father) 2. [redacted] (Robbie's Mother) 3. [redacted] (H.S.C. Energy Division) I am 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	Dated 12 March 2015 Signature _____ Mr. Richard G. Taylor, Senior Coroner for East Lancashire District

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