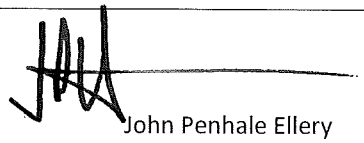
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] Head of Environmental Maintenance Shropshire Council 107 Longden Road Shrewsbury SY3 9EL 2. [redacted] Senior Lawyer (Team Leader) Professional Support Legal Services Richard Fairclough House Knutsford Road Warrington WA4 1HG
1	**CORONER** I am John Penhale Ellery, Senior Coroner for the coroner area of Shropshire, Telford & Wrekin
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 31st December 2014 I commenced an investigation into the death of Daniel Lee HODGIN deceased, 20 years old. The investigation concluded at the end of the inquest on the 14th April 2015 at the Shrewsbury Coroners Court. The conclusion of the inquest was accidental death. The medical cause of death was: 1a) Immersion in water
4	**CIRCUMSTANCES OF THE DEATH** The body of the deceased was found in the River Severn at Cressage on the 31st December 2014. The deceased had last been seen alive on Sunday morning the 23rd November 2014 at 05:27 when he was recorded on a CCTV camera outside a property at Dorset Street, Castlefields, Shrewsbury near to the River Severn in Shrewsbury. The distance from the River Severn by Dorset Street to Cressage was 24 miles down-stream. The deceased had been on a night out in Shrewsbury with friends and had become lost and disorientated. The post mortem and toxicology tests indicated a level of 196 mg/dL which represented a high level of alcohol in his body at the time of death. It is more likely than not that at soon after this last sighting the deceased made his way through an open gate and went the short distance down a flight of steps on to the towpath by the River Severn which was then in flood and covered the towpath. It was dark and the deceased had not been to that area before. It is likely that once on the towpath he either stepped off or slipped into the river drowning or suffering fatal shock from entering the cold 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 MATTERS OF CONCERN are as follows. – (1) According to a Shropshire Council plan of the Dorset Street area the gate at Dorset Street leading to the towpath should have been closed and locked when the water level at the Welsh Bridge gauge reached 1.95 meters. (2) At between 5 a.m. and 6 a.m. on the 23rd November 2014 when the deceased most likely entered the water, the level at the Welsh Bridge gauge was recorded at between 2.00 and 1.99 meters. (3) Had the gate been closed and locked the deceased would have been unable to pass through. (4) No clear system was established whereby the Environment Agency notified, or was required to notify, Shropshire Council as to the water level or likelihood of the water level reaching 1.95 meters at the Welsh Bridge gauge. The Council's instruction to close and lock the gate at Dorset Street was bound to fail, there being no effective system in place to achieve the same. (5) River safety in Shrewsbury has been a matter of concern for some time. In 2010 I made what were then two Regulation 43 Reports to Shropshire Council in respect of alcohol related deaths. (6) The concerns raised here not only affect those adversely affected by alcohol but anyone who may be unfamiliar with the area when the river is in flood and is dangerously high covering the towpath. For completeness, and this does not directly concern the Environment Agency, there was a recent reported incident of a pram being blown into the River Severn where the towpath was unprotected by railings.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 15th June 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] – mother of deceased. 2. [redacted] – father of deceased 3. Inspector [redacted] of West Mercia Police, Shrewsbury Police Station 4. The Chief Coroner, His Honour Judge Peter Thornton QC 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	20th April 2015  John Penhale Ellery