

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO:

1. Canal & River Trust

1 CORONER

I am Julie Robertson, Assistant Coroner for the Coroner area of Manchester North

2 CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

3 INVESTIGATION and INQUEST

On the 16.6.16 I commenced an investigation into the death of Flavio Rafael Pizarro.

4 CIRCUMSTANCES OF DEATH

The deceased died after her entered the water at Lock 62 by jumping into the canal with friends. There were no signs warning of the dangers of swimming or safety aids. After entering the canal the deceased got into difficulties as he was unable to swim. Despite rescue attempts by passers-by and attending police and fire personnel the deceased spent a significant period submerged. Having been removed from the water he was conveyed to Manchester Children's Hospital where he died on 14 June 2016.

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:-

There was no signage warning of the dangers of swimming or safety aids at Lock 62 or within the nearby vicinity. There remains no signage at all locks in the immediate area and children continue to play in and near the water despite correspondence dated 5 July 2016 from the Canal % River Trust that stated that signs would be erected at all locks in the immediate vicinity. Future deaths could be prevented by the presence of signs and safety aids.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 18.1.17. 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 namely:The family of the deceased and Greater Manchester Police.

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 from. 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 Date: 23.11.16 Signed: