Karen Dilks
Senior Coroner for the City of Newcastle Upon Tyne

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Sunderland City Council** Chief Executive Chief Executive Office Civic Centre Burdon Road Sunderland SR2 7DN
1	**CORONER** I am Karen Dilks, Senior Coroner for the City of Newcastle Upon Tyne
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 the 2 September 2016 I commenced an investigation in to the death of Liam Hall, aged 17 years. The investigation concluded at the end of the inquest on the 13 July 2017. The conclusion of the inquest was accidental death.
4	**CIRCUMSTANCES OF THE DEATH** On 30 August 2016 Liam Hall together with three friends, travelled to Roker Beach (Harbour Area). All four entered the sea in an inflatable dinghy. They encountered difficulties whilst in the water including water ingress into the dinghy. Liam who had very limited swimming ability chose to leave the dinghy entering the water leading to his death by drowning. A police officer and Liam's mother gave evidence at the inquest that in the harbour area there was no Warning signage and also lifeguard supervision.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) No appropriate signage warning of the risks of entering the water and of the increased risks associated with the use of inflatable devices in the Roker Harbour area. (2) No lifeguard supervision in that area.

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6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Sunderland City Council 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 18 September 2017. 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] • Sunderland Safeguarding Board I have also sent it to: • [redacted] Assistant Head of People's Services Directorate, Sunderland City Council. • [redacted] Area Lifesaving Manager of RNLI who may find it useful or of interest. 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	Dated 27 July 2017 Signature _____ Senior Coroner for the City of Newcastle Upon Tyne

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