REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Parkhill Group of Companies, Fernhill offices, Sutton Newport, Shropshire TF10 8DJ** **2. Chief Executive- Walsall Metropolitan Borough Council** **3. Chief Coroner**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 21 June 2017, I commenced an investigation into the death of the late Spencer Lloyd Hurst. I held a pre-inquest review hearing on the 9 August 2017. The resumed inquest is scheduled to take place on 18 September 2017 at the Black Country Coroner's Court. The provisional cause of death is: 1a Drowning
4	**CIRCUMSTANCES OF THE DEATH** i) On the evening of the 20 June 2017, a 15 year old male, Spencer Hurst was with a group of his friends that went into a lake on private land in Ryders Hay Lane, Pelsall. ii) The lake is locally known as Ryders Hayes Mere and is described as a flooded open cast coal pit and contains a small island. iii) It appears the group were swimming together when Spencer has got into trouble and went below the surface of the water. Despite assistance from his friends they were unable to locate him. iv) Sadly his body was recovered by the emergency services a short time later and he was pronounced deceased.
5	**<u>CORONER'S CONCERNS</u>** During the course of the investigation and pre-inquest hearing review, matters giving rise to concern were noted. 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. Evidence emerged during the investigation and pre-inquest hearing review that

	another young male had died in very similar circumstances at the same location on the 11 June 2007. 2. Despite this being the second death, evidence emerged that there have been no adequate notices displayed to warn of the risks of swimming in the lake and no evidence of any fencing or appropriate measures taken to mitigate the risks.
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. 1. You may wish to consider as a matter of urgency implementing measures to try and prevent or deter swimmers in the lake by restricting access or providing monitoring of the site. 2. The responsible local authority has also been notified to offer appropriate advice or consider any relevant action that needs to be taken.
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 October 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; Family. 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	**16 August 2017** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**