REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Health and Safety Executive (HSE) and Royal Society of Prevention of Accidents
1	CORONER I am Alison Mutch ,Senior Coroner, for the coroner area of South Manchester
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 29th June 2018, I commenced an investigation into the death of Dwayne Daniel Ryan Thompson. The investigation concluded on the 17th January 2019 and the conclusion was one of accidental death. The medical cause of death was 1a hypoxic brain injury;1b freshwater drowning
4	On 28th June 2018 Dwayne Daniel Ryan Thompson went with friends to the Reservoir at Audenshaw. Whilst swimming he got into difficulties and went underwater. Emergency services recovered him from the water and transferred him to Tameside General Hospital. Resuscitation continued. He had suffered a catastrophic brain injury as a result of being underwater. He died at Tameside General Hospital on 28th June 2018.
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: The inquest heard that Dwayne Thompson had significant learning disabilities. This reservoir had a fence to prevent access but this was regularly damaged and access was gained with relative ease by locals who used the reservoir to swim in/cool down in during the heat of the summer. It was unusual in having a fence and the majority of reservoirs were easily accessible by the public. There was signage to warn of the risks of swimming in reservoirs. This signage

	was used across all reservoirs including those with open access to them. It was the main way in which the utility company made the public aware of the risks of the reservoirs. The signage complied with the HSE guidance but the inquest heard that the signs had been in existence for many years and there was no evidence that the needs and understanding of those with learning disabilities had been considered when they were devised.
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 12th April 2019. 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 [redacted] Mother of the deceased and United Utilities 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	Alison Mutch OBE HM Senior Coroner 15th February 2019