John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Canal and River Trust c/o Freeths LLP, Floor 3, 100 Wellington Street, Leeds LS1 4LT
1	**CORONER** I am John Adrian Gittins, Senior Coroner for North Wales (East and Central)
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 2nd of June 2016 I commenced an investigation into the death of Kristopher John McDowell (DOB 5.12.1997 DOD 31.5.2016) The investigation concluded at the end of the inquest on the 6th of March 2019. The conclusion of the jury at the inquest was one of death by misadventure, the Cause of Death being recorded as 1(a) Chest Trauma
4	**CIRCUMSTANCES OF THE DEATH** On 31st of May 2016 whilst walking home from work with friends, the Deceased went through the uprights on the Pontcysyllte aqueduct bridge onto the non-pedestrian side whereby the upright rail that the Deceased was holding onto became detached and the Deceased fell from a height to his death
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. – (a) The average space between the uprights on the parapet on the aqueduct is 195mm whilst the current industry standard is 110mm as a result of which there exists a risk that a person might be able to pass between them. This is a particular risk for children using the aqueduct but it is also a significant risk for young persons or adults being of sufficient width for them to pass through in circumstances whereby it was their intention to gain access to the non-pedestrian side of the parapet for a purpose which would not be considered the intended use of the structure. In my opinion, the use of signage alone, warning users of the potential risk, does not adequately mitigate the risk of a person passing through the uprights and falling from the aqueduct.

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	(b) Evidence provided by an expert instructed by the Canal and River Trust (CRT) indicated that it was his belief that the upright became detached as a result of a lifting action which dis-engaged the nib on the bottom of the upright from the socket on the outside of the parapet. The evidence provided to the inquest by engineers from CRT advised that their inspection procedures provided for an Annual Inspection which included testing for the extent of embedment by a push/pull/lift test, however in my opinion the subjective elements of this test this would permit inconsistencies in the information which it provides. Furthermore, exact measurements of the degree of embedment of uprights would only routinely be established in the course of a Principal Inspection which takes place every twenty years and as a result it is difficult for there to be an accurate/regular assessment of the rates of possible deterioration and hence the true extent of embedment. In my opinion, the testing processes currently adopted (in regard to the matters detailed above) are inadequate to ensure that the uprights are properly engaged at all times.
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 2nd May 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 Family of the Deceased In the public interest I have also made the report available to the Health and Safety executive and to members of the press. 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 7th March 2019 Signature_____ Senior Coroner for North Wales (East and Central)

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