REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used after an inquest.

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

- Chief Executive, Craven District Council, 1 Belle Vue Square, Broughton Road, Skipton, BD 23 1FJ, and
- 2. Chief Executive, Yorkshire Dales National Park, Colvend, Grassington, Skipton, BD23 5LB
- 3. Chief Executive, Yorkshire Water, PO Box 52, Bradford BD3 7YD

1 CORONER

I am JOHN BROADBRIDGE Assistant Coroner, for the Coroner area of North Yorkshire, Western District

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 3 August 2020 an investigation commenced into the death of MOHAMMED BILAL ZEB, aged 18 years. The investigation concluded at the end of the inquest on 25 March 2021. The Conclusion of the inquest was that the deceased died because of drowning, to which COVID 19 and asthma were said to be contributory, and that his death was accidental.

4 CIRCUMSTANCES OF THE DEATH

On 31 July 2020 the deceased was at Linton Falls on the River Wharfe near Linton with family and friends. Although he could not swim, he jumped into the River and got into difficulties. Persons present tried to help but he became unresponsive. He was recovered eventually to a large rock where resuscitation compressions were attempted, then to the riverbank. He was recognised as deceased there at 21.18 hours that same evening from drowning.

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 could 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) Recognising the Deceased's inability to swim and that he was soon unresponsive, there were nevertheless no aids eg flotation aid, throw line or water rescue reach pole to help the rescuers, or the deceased himself if he had been responsive, accessible at the scene of the incident. (2) Police Officers and paramedics courageously had to swim and put themselves at risk to try and reach the casualty and support the deceased's body while CPR was attempted in less than helpful physical positions and conditions for recovery of an inert casualty. Recognising that the Falls are a popular open, natural attraction, valued for its natural features, nevertheless the steep banks and rocks permit no ready access to places of safety and support for casualties.

It was not until a team from Upper Wharfedale Fell Rescue attended that he was able to be moved to a more suitable location.

(3) No one present appeared to have been aware of any safety warnings either at the location or by other media about risks to life from cold water, current/ speed of water flow, underwater obstructions and obstacles, all 'unseen' hazards. Further that such risks do not disappear - instead vary, remaining hazardous - in summer months even after drop in water levels.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 3 June 2021 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



I have also sent it to:

North Yorkshire Fire and Rescue Service of Alverton Court, Crosby Road, Northallerton, DL6 1EE

and

North Yorkshire Police, Alverton Court, Crosby Road, Northallerton, DL6 1BF and

Upper Wharfedale Fell Rescue Association of Hebden Road, Grassington, Skipton, BD23 5LB

and

National Water Safety Forum at info@nationalwatersafety.org.uk 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

30 March 2021

SIGNED JNB roadbudge