REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Ynys Mon County Council**
1	**CORONER** I am DEWI PRITCHARD JONES Senior Coroner for the coroner area North West Wales
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 28th November 2014 I commenced an investigation into the death of ISAAC NASH Aged 12 years. The investigation concluded at the end of the inquest on 21st January 2015. The conclusion of the inquest was that the medical cause of death was drowning and that death was due to Misadventure.
4	**CIRCUMSTANCES OF THE DEATH** On 29th August 2014 the deceased together with his parents and other members of his family went to the beach at Aberffraw with the intention of playing on the beach and bathing in the shallow water. The family had been to this beach on several occasions and understood it to be a beach that is safe for children. The adult members of the party were aware of a potential hazard in the form of a possible strong current where the river enters the bay and therefore they located themselves some distance to the south of the estuary. The members of the party were not aware that when they arrived at the beach the ebbing tide was at its peak due to the tidal flow in the Irish Sea, the ebbing tide in Aberffraw Bay and the flow of water in the river. The deceased and his brother were playing in the shallow water of the bay but, unfortunately, they were drawn towards the river estuary. By the time the adults realised this the children were in an area of a strong ebbing tide. They immediately realised the danger and went to recover the children who were being swept out to sea. Two adults attempted to save the children but encountered strong tidal conditions with the result that only one child was saved and the deceased was swept out to sea. The body of the deceased was never found. At the Inquest concern was expressed by the family and by local residents that Aberffraw Bay is known to be a beach that is safe for children but there is no way of warning those enjoying the beach that there is an area where the river estuary is located where at times there can be very strong currents.
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. – (1) Whereas it is acknowledged that there is no such thing as a safe beach Aberffraw Bay is generally considered to be a beach that is safe for children. Unfortunately, the area where the river estuary is located is, at times, subject to very strong currents and there is no way by which a person using the beach can be aware of this other than by having local knowledge. In this case, the adults accompanying the deceased were extremely sensible and safety conscious but could not have been aware of the strong tidal conditions prevailing when the children were playing on the beach. If they had been aware of the strong tide at that time they may either have not gone onto the beach or would have chosen a location in the bay where the tidal stream is not great and would have ensured that the children would not stray into the strong tidal area. I would suggest that you consider erecting signs to warn the public of the potential danger in the river estuary part of Aberffraw Bay.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 1st April 2015. 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] and to the LOCAL SAFEGUARDING BOARD. I have also sent it to [redacted] 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 January 2015** **SIGNED:** [redacted] **DEWI PRITCHARD JONES** **SENIOR CORONER**