ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The County Solicitor** **Devon County Council** **Room G26** **County Hall** **Topsham Road** **Exeter** 2. **The Managing Director** **North Devon Council** **PO Box 379** **Barnstaple** **EX32 2GR**
1	**CORONER** I am Dr Elizabeth Ann Earland, Senior Coroner for the coroner area of Exeter and Greater Devon.
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 16 September 2013 I commenced an investigation into the death of Keenan John WALSH, aged 4 years. The investigation concluded at the end of the Inquest on Wednesday 25 May 2016. The conclusion of the Inquest was a Narrative Conclusion, details as follows: *"Keenan, a non-swimmer, died as a result of a tragic drowning accident in the 9 foot deep end of a heated swimming pool at Bicclescombe Grace, Kingsley Avenue, Ilfracombe, whilst attending a large family party.* *Sometime between 17:45 hours and 18:17 hours 23 August 2013, Keenan submerged in the deep end of the pool whilst inadequately supervised in company of a permutation of 12 children jumping in and out and two adults, neither of whom were available to rescue him. The slope of the deep end was a factor. Vision was obscured by large numbers of inflatables.* *Immediate attempts at resuscitation and subsequent transfer to North Devon District Hospital, then Paediatric Intensive Care Unit at Bristol Children's Hospital, failed to avert his subsequent death from Ia. Complications of near-drowning."*

4	**CIRCUMSTANCES OF THE DEATH** See 3 above.
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) At the time of the incident private holiday lets with swimming pools were not regulated by the Health and Safety Department of Local Authority Environmental Health, despite tourism being a significant part of local economy. See recording of evidence of [redacted] Environmental Health Officer (North Devon Council). (2) Although there was a limited amount of signage the profile of the swimming pool fell outside accepted standards and presented a significant hazard to non-swimmers approaching a sharp slope to the deep end. (3) The ratio of competent adults to children was one adult to anything up to 12 children at the time of this incident. This ratio was against the advice of the proprietors but unenforceable. Responsibility lay with adult family members.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you your organisation have the power to take such action. I refer you to the advice received in Evidence from [redacted] Environmental Health Officer in her report. • ***"Pool Profile*** *The gradient of the swimming pool in water depths of 1.5m and 1.35m had been calculated as approximately 1 in 3.7. This means that the pool does not comply with either the new European Standard BS EN 15288-2.2008 or the standard outlined in HSG 179 these being 1 in 10 and 1 in 15 respectively. The Officers have strongly recommended that the owners consider re-profiling the floor of the pool to a gradient which meets the requirements of those standards.* *In the meantime Officers recommended that:* *a) a diagram showing pool depth and profile should be displayed poolside.* *b) The sides of the pool should be clearly marked at areas of steep gradient with signs erected warning of the sudden change in depth.* *c) To consider the possibility of introducing a physical barrier between the changes of water depth. This could include the provision of floating buoys, for example.* *d) Consider clearly marking the areas of steep gradient with coloured pool tank markings.* • ***Signage*** *a) Clear, water depth signs should be provided which are clearly visible to the bathers, when they are both on the pool surrounds and in the water.*

	b) Signs indicating general 'do's' and 'don'ts' should be placed prominently poolside. Warning signs such as 'No Diving', etc., should be displayed in a pictorial format to comply with the Health & Safety (Safety Signs & Signals) Regulations 1996. • ***Access to Pool*** *a) A high handle, 'out of reach' of younger children should be provided on the main entrance door to the pool hall.* *b) Access to the pool hall is located close to deep water. Bathers may enter the water at the first entry point without checking that the water depth is appropriate – a particular problem for children and inexperienced swimmers.* [redacted] *suggested that a physical barrier such as a guard-rail could be provided.* *Under the circumstances we would agree that a guard-rail and warning signs would be appropriate."* Further to this she stated in Evidence that it had recently been decided by the Legal Department that such holiday lets would fall to be included with the provisions of Section 3 Health and Safety at Work Act 1974 (the proprietors being self-employed). If this is so I invite you to clarify this point with all involved in the tourist industry in the county and take such action as is felt necessary.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 22 July 2016. I, the Senior 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, who may find it useful or of interest. [redacted] (Father of Deceased) [redacted] (Mother of Deceased) 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	**Signed** ..... **Dr Elizabeth A. Earland** **HM Senior Coroner** **Dated this 27th day of May 2016**