	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Association of British Travel Agents**
1	**CORONER** I am Penelope Schofield, Senior Coroner, for the area of West Sussex
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 4th March 2016 I concluded the inquest into the death of Alfie Wayne Eddie Gray born 2nd November 2007 (aged 7 years), who died on 7 July 2015. I determined that Alfie Gray had died an accidental death having drowned.
4	**CIRCUMSTANCES OF THE DEATH** On 6th July 2015 Alfie Gray and his family travelled to Sharm El Sheikh, Egypt along with another family.. They stayed at the Reef Oasis Beach Resort. The holiday had been organised by the Global Travel Group. On 7th July 2015 Alfie was playing in the pool at the hotel resort along with other family members. The pool had a waterfall coming into it. The pool should have been monitored by lifeguards. Just after lunch Alfie's mum left the pool side to collect a bottle for her baby and when she returned she noticed that Alfie was missing. Staff at the resort did not take the incident seriously and it was left for family and other holiday makers to search for Alfie. Sadly he is found at the bottom of the pool under the waterfall. The time between the family realising that he was missing and Alfie being found was around 45 mins. It was clear from the evidence that had he been found sooner he may well have been able to have been resuscitated.
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) **The provision of lifeguards**. It appeared that the number of lifeguards on duty at this resort were inadequate. The life guards did not have any medical training and communication with the holiday makers proved difficult when help was needed. (2) The lifeguards went off duty for an hour over lunchtime. This information was not communicated to the family either by the hotel or the travel company. I consider that the issues raised in this case have much wider implications which should be addressed by Travel Companies so that future deaths do not occur in similar circumstances and that action should be

	taken to reduce the risk of deaths.
	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 by addressing this issue with your members.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th September 2016. 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: 1. [redacted] parents of the deceased. 2. Global Travel Group 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	**DATE: 25th July 2016** **SIGNED: Penelope Schofield, Senior Coroner, West Sussex**