REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. MR JAMES KNIGHT** **DIRECTOR** **WAVENEY RIVER CENTRE** **STAITHE ROAD** **BURGH ST PETER** **NORFOLK** **NR34 0BT**
1	**CORONER** I am JACQUELINE LAKE, senior coroner, for the coroner area of NORFOLK
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 May 2016 I commenced an investigation into the death of MAYA GRACE KANTENGULE, AGED 7 YEARS. The investigation concluded at the end of the inquest on 27 JULY 2017. The conclusion of the inquest was MEDICAL CAUSE OF DEATH: DROWNING. CONCLUSION: ACCIDENT.
4	**CIRCUMSTANCES OF THE DEATH** On 1 May 2016 Maya attended a swimming pool birthday party held at Waveney River Centre. Maya was unable to swim independently. Towards the end of the party, Maya was seen unresponsive at the bottom of the swimming pool. Emergency Services were called and Maya was taken to the James Paget University Hospital where she was declared dead later that day.
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) Prior to Maya's death in 2004, independent Contractors had drawn up the Risk Assessments and other Health and Safety documentation relating to the organisation and the use of its facilities by staff and the public. Since 2011, the Risk Assessments were updated internally. These had been deemed "*suitable and correct*" by South Norfolk Council. Since 2004 there had been no formal Health and Safety Training of Directors or staff at Waveney River Centre (WRC), in particular by those responsible for health and safety and by those updating, reviewing and checking health and safety documentation. (2) Although a Risk Assessment had been completed and updated with regard to the use of the swimming pool in 2016, there was no separate Risk Assessment in place with regard to the holding of swimming pool birthday parties. It was clear from the evidence it was believed by those at WRC to be the responsibility of the person holding the birthday party who would be responsible for the safety of the guests.

	(3) Although safety procedures had not been followed on the morning of the swimming pool party, such as going through safety rules with the pool hirer and signing of documentation, and in addition the CCTV (an additional measure used by WRC to check on the pool area) was known to not be working, no checks were made on the pool party by members of staff to ensure safety rules were understood and followed. (4) There was no evidence of awareness of staff with regard to health and safety in the pool area. (5) Since Maya's death, the decision has been made to hold no further external pool parties. The Swimming pool is still used by the public and WRC is still involved in activities involving the public and water. (6) Fourteen months have passed since Maya's death and there has been no formal health and safety training of Directors and staff. It was said on behalf of WRC they are awaiting the outcome of the inquest before arranging formal health and safety training and in addition the member of staff responsible for updating and reviewing Risk Assessments has suffered with PTSD as a result of Maya's death. There was no indication that anyone else had been considered in respect of undergoing health and safety training, such as those ultimately responsible for health and safety at WRC or any other member of staff.
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 3rd October 2017. 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] Local Safeguarding Board South Norfolk Council 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** 8 August 2017. **SIGNED BY CORONER** [signature]