

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Drayton Manor Theme Park Alton Towers Legoland Thorpe Park Merlin Entertainments Limited Lightwater Valley Theme Park</p>
1	<p>CORONER</p> <p>I am Margaret Jones the Assistant Coroner, for Staffordshire (South).</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 17/05/2017 I commenced an investigation into the death of Evha Jannath, The investigation concluded at the end of the inquest on 11th November 2019. The conclusion of the inquest was Accidental Death</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Evha Jannath was 11 years of age. On the 9th May 2017 she went on a school trip to Drayton Manor Theme Park. Evha went onto a water rapids ride known as Splash Canyon. No adult was required to be in the boat because Evha met the park height requirement of 1.1m (she was 1.47m in height) over which no adult was required.</p> <p>Towards the end of the ride Evha stood up in the boat and at the same moment the boat hit a buffer which was designed to direct the boat on its way toward the end of the ride. As a result of the impact Evha was projected into the water flume. The water at that point was 70-80cm deep. She was seen clinging to the buffer, she spoke to a bystander and then walked along the wall towards a wooden conveyer belt designed to lift boats out of the water at the end of the ride. She climbed onto the conveyer which was (understandably) wet and slippery and fell off into deep water.</p> <p>The CCTV covered 50% of the ride. A review of all 7 ride facing cameras showed that Evha was visible. She could be seen out of her seat and not holding the centre rail on all camera views. This had not been observed by the ride operator and consequently no tannoy warnings were given. It took 18 minutes for Evha to be located and recovered from the water. A review of CCTV coverage for that day from 10.30 am (the time the ride opened) to 2.00pm, (the time of the incident) revealed at least 70 incidents of guests standing the in the boats.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows:</p> <p>(1) The ride had been staffed with one attendant, one operator and a trainee operator. The ride operator tasks included stopping and starting the lift to space boats in order to assist the attendant with loading, unloading and turning empty boats. Additionally on this day the operator had training responsibilities. Consequently it was not possible to monitor the CCTV adequately. The operator training in respect of monitoring the CCTV was limited to being told to watch it.</p>

(2) No safety warnings were given to guests loading onto the boats. The attendant was not trained to give safety warnings and it was not covered in the Code of Safe Working Practice. In any event even if safety warnings had been given guests might not have been able to hear them because of background noise. The attendant's ability to give safety warnings was limited due to working as a sole attendant which required him to load and unload boats with the emphasis being placed on unloading.

(3) Warning signs paced around the ride advised guest to remain seated and hold the centre rail but did not spell out the consequences of failing to stay seated (the risk of falling out and drowning), Signage in the boats was worn and in part illegible.

(4) Staff had not been trained in water rescue and there was no water rescue equipment available.

(5) Ride operators had no clear understanding of the emergency procedure to be followed if a guest fell into the water.

(6) Management staff did not accept that guest safety measures (CCTV, safety instructions and signage) had failed.

The ride at Drayton Manor Park was decommissioned following the accident and will not be recommissioned without the approval of the HSE. Some assurances were given at the inquest that if the ride is to be reopened it will only be after considerable improvements have been made.

Following the death of Evha the Health and Safety Executive issued the following 'Information Note on Safety at water rides' which is applicable to all theme parks.

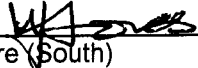
HSE Information Note
Safety at water rides

People can get into difficulties on fairground rides for a variety of reasons; this is foreseeable, well documented and the risk of serious harm is heightened if the ride experience includes deep and/or moving water. Ride controllers have duties to take reasonably practicable steps to ensure the safety of people on their rides. On water rides HSE expects that:

- given that incidents can happen anywhere on a ride, operators are both able to, and do actively monitor the whole of the ride at all times, either by direct sight or via effective CCTV and similar
- operators should give clear, unambiguous advice and instructions about safety on the ride before riders board/during boarding
- operators should be able to identify individual boats and quickly address any emerging problems, firstly through PA systems or similar
- if a person enters the water, the operator should raise the alarm immediately and staff should be deployed without delay to the correct part of the ride to effect rescue
- operators will have identified and taken action to eliminate, control or manage any additional hazards which may increase the risk of drowning or impede rescue in the event of a rider entering into the water
- any theming or participatory items such as water cannons or similar items whether on the boat or the bank, should not encourage riders to adopt unsafe positions
- suitable and sufficient equipment is readily available along the ride so that rescue can be effected.

16 May 2017

It is appropriate that Drayton Manor Theme Park manager should respond in detail to the matters raised at the inquest and that all other theme park managers should respond in respect of the HSE Safety Notice.

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 8 January 2020. I, the Assistant Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and the following Interested Persons, the family of Evha Jannath, HSE, Jameah Academy and to the Staffordshire Safeguarding Board (where the deceased was under 18)].</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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 Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.</p>
9	<p>Dated 13 November 2019</p> <p>Signature  for Staffordshire (South)</p>