ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Tendring District Council**
1	**CORONER** I am Caroline Beasley-Murray, senior coroner, for the coroner area of Essex
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 12 August 2019 I commenced an investigation into the deaths of 14 year old Malika Shamas and 18 year old Haider Ali. The investigation concluded at the end of the inquest on 17 February 2020. The conclusions of the inquests were that both died as a result of an accident. The causes of death were respectively 1a) Drowning and 1a) Pneumonia and Brain damage 1b) Drowning
4	**CIRCUMSTANCES OF THE DEATH** The brother and sister got into difficulties while bathing in the sea, near a groyne, at Clacton-on-Sea on 8 August 2019. They had travelled along with other family members from their home in Luton for a day at the seaside. In 2018 there had been a previous drowning fatality incident on Clacton beach
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 inadequacy of the signage. Tendring District Council asserted that this equates to national standards but the court had qualms about the effectiveness of the existing signage. 2. The Danger sign by the relevant groyne was difficult to read. The wording and layout could be improved and maybe such notices by each groyne would assist. There was vivid evidence from the young victims' mother of the swirling nature of the currents around the relevant groyne 3. Mindful that there had been a previous teenage drowning fatality at Clacton beach near the pier, warning notices by the pier might assist. 4. The Beach Information notice on Clacton's West Beach contains a great deal of important information for beach users but some of the information

	was written in small text and hence difficult to read. The court wondered indeed how many passers by actually read the information. The council could look into the improvement of these notices and whether there should be more of them along this stretch of beach. Perhaps there could be some more child friendly information boards. 5. The beach patrol officer was 395 metres away from the fatality incident and was unable even with the use of binoculars to discern the nature of the incident.. More extensive surveillance would help on such a busy stretch of beach. 6. Perhaps more liaison with the RNLI which provides beach safety measures on some beaches would benefit the council's efforts to provide beach safety.
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 2nd April 2020. 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 – The family The RNLI The Maritime and Coastguard Agency 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	**18 February 2020 Caroline Beasley-Murray senior coroner Essex**