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HM Senior Coroner for Essex

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1- Chartered Institute of Environmental Health** **2- Institute of Occupational Safety and Health**
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 29 April 2013 I commenced an investigation into the deaths of Josephine Foday and of Komba Kpakiwa. The investigation concluded at the end of the inquests on 15 May 2014. The conclusions of the inquests were Accident. Natural The cause of death for both 1a) consistent with drowning.
4	**CIRCUMSTANCES OF THE DEATH** Both Ms Foday and Mr Komba were found floating in the swimming pool at Down Hall Country House Hotel, Hatfield Heath, Essex. Their deaths were confirmed shortly thereafter.
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 pool profile was inherently dangerous 2)The pool profile, including depths and gradients were not considered when carrying

	out the hazard identification that is required in the swimming pool guidance document HSG 179 3) The risk assessments did not cover the accurate profile information and any other specific risk factors 4) There were no lifeguards provided and the duty holders of the pool did not ensure that there were in place effective controls in place to reduce the risk of drowning 5) It did not appear that non swimmers or poor swimmers had been considered in the risk assessment process. 6) The pool operators had not sought the advice of a swimming pool expert in order to decide what would constitute adequate controls where constant pool supervision was not provided in this unusual hopper type pool. The operators were relying on CCTV as a method of supervision but this was not monitored and no system was put in its place when it became unavailable. 7) Some of the signage provided was not clear, accurate and unambiguous. 8)The pool operators did not ensure that in a pool of over 1.5m depth there were always on the premises, when the pool was open, staff trained in aquatic rescue techniques. .
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 18th Jul. 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:- Fentons Solicitors, Berrymans Lace Mawer Solicitors, Weightmans LLP, [redacted] -Uttlesford District Council, [redacted] Specialist on Aquatic Safety. 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	**23rd May 2014** **HM Senior Coroner for Essex**