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:** This Report needs to go to the Chief Coroner and the owner of Croyde beach. The owners of the beach, Parkdeane Holidays – Ruda Holiday Park Ltd., Croyde Bay, North Devon, EX33 1NP. North Devon District Council, Civic Centre, North Walk, Barnstaple, Devon, EX31 1EA. [redacted] Support Officer, Maritime and Coastguard Agency, Bay 3/20, Spring Place, 105 Commercial Road, Southampton, SO15 1EG. Royal National Lifeboat Institute, West Quay Road, Poole, Dorset, BH15 1HZ.
1	**CORONER** I am Mr John Geoffrey Tomalin, Deputy Coroner for the Exeter and Greater Devon Area.
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 THE 31st December 2013 I commenced an investigation into the death of Rebecca Jodie CURTIS-SMALL, aged 42. The investigation concluded with an inquest held on 9th October 2014. The conclusion of the inquest was Accident Death - On the 31st December 2013 the Deceased was in the water with her family at Croyde Bay, North Devon, when she found herself in difficulties due to sea conditions and a rip tide. After a search involving Lifeboats, Coastguards and Royal Air Force Search and Rescue Helicopter lasting 1½ - 1¾ hours at 1302 hours the Deceased was airlifted to North Devon District Hospital in Barnstaple where she died from I(a) Drowning and Hypothermia.
4	**CIRCUMSTANCES OF THE DEATH** 1. Circumstances of the death. The deceased and her family had gone swimming in Croyde Bay in North Devon on 31st December 2013. A rip tide had taken the deceased out to sea and as a result, a full scale search was instigated involving the coastguard service, search and rescue helicopters and both the RMLI all-weather lifeboat and the inshore lifeboat. The sea conditions were difficult with a large swell and high waves. The search lasted approximately 1 hour 45 minutes until the deceased was found on the shoreline and taken by helicopter to the North Devon District Hospital where rewarming and resuscitation attempts were commenced but stopped after one hour. During the Inquest reference was made to the signs displayed at Croyde beach which the family claimed they had not seen. Those signs refer to potential hazards including rip currents. The Inquest was told by HM Coastguards that these were the prescribed RNLI signs. The evidence of the coastguards were that the signs could perhaps be better displayed because the warning part of the sign could not be seen on the entrance to the beach as the sign was erected parallel to the slipway entrance onto the beach. The Inquest was told that there are three rip tides at Croyde, one on either side of the bay nearest the rocks and one towards the centre where there is a sand bar although this rip current would move depending upon sea conditions.

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. That the appropriate signage is displayed in a way that can easily be seen on each of the entrances to the beach. 2. Whether the sign could refer to any specific riptide hazards known of at the beach in order to warn members of the public using the beach at different times of the year and different states of the tide, that rip tides would be more hazardous.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 30th December 2014. 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 owners of the beach, North Devon District Council, Civic Centre, North Walk, Barnstaple, Devon, EX31 1EA. [redacted] Support Officer, Maritime and Coastguard Agency, May 3/20, Spring Place, 105 Commercial Road, Southampton, SO15 1EG. Royal National Lifeboat Institute, West Quay Road, Poole, Dorset, BH15 1HZ. 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	**4th November 2014** **Signed** ..... **Mr John G Tomalin** **HM Deputy Coroner for the Exeter and Greater Area** **Room 226** **County Hall** **Topsham Road** **EXETER** **Devon EX2 4QD**