REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] **Chief Executive - Environment Agency** **Seacole, Block 2, 2 Marsham Street, London SW1P 4DF.** **2.** [redacted] **Director General - National Trust** **Heelis, Kemble Drive, Swindon, Wiltshire, SN2 2NA.**
1	**CORONER** I am Mrs Heidi J. Connor, senior coroner for the coroner area of Berkshire.
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** I conducted an inquest into the death of Jordan Shaun Mhlanga-Veira at Reading Town Hall on 4th November 2021. I recorded a conclusion of accident.

4	**CIRCUMSTANCES OF THE DEATH** The family asked me to refer to the deceased as Jordan during the inquest. I will respect that wish in this report. Jordan was born on 16th August 2005. 31st May 2021 was a hot Bank Holiday Monday, and one of the first days on which people were allowed to socialise outdoors after the lockdown period. Jordan, then aged 15, arranged to meet at a site known locally as "[redacted] in Cookham, Berkshire. I visited the site, and also heard in evidence that the [redacted], [redacted], is shallow and is frequently used by members of the public. However, the river depth drops dramatically in the middle of the river. It would seem that Jordan was playing with his friends, and without realising, got into difficulty and subsequently drowned in the river. The evidence showed that one of his friends had also got into trouble earlier that day, but had managed to get himself to safety. Contrary to popular belief, a drowning person does not always wave and shout. A witness on a boat described seeing Jordan's head go under the water and sounded the alarm. Extensive searches were carried out involving numerous emergency services, but tragically, Jordan was found dead in the early hours of the following morning. His cause of death was drowning. The National Trust is the landowner for the area in question and gave evidence that it is keen to assist in improving safety in this area where possible. The closest throw rope at this scene is approximately 200 metres away. Tragically, this throw rope was put in place following a similar death of a young teenage boy in 2014. The scene of this tragedy is regularly used by many members of the public, effectively [redacted]. There are no safety measures in place at the site. We also heard in evidence about the clear difference between tidal and non-tidal waters, in safety terms. There is currently no statutory framework around safety measures applied to inland waters.

	As set out in the case of R (Dr Siddiqui and Dr Paeprer-Rohricht) -v- Assistant Coroner for East London, the issuing of a Regulation 28 Report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature.
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 could 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. Whilst it is not a matter for the coroner at an inquest to recommend particular safety measures, I ask that safety measures at the site be reviewed urgently, to include consideration of warning signs, position of throw ropes, and consideration of buoys in the water (at the point where it becomes deep). I appreciate that many of these measures will contain both advantages and disadvantages, and this will be a matter for debate amongst the appropriate agencies referred to in this report. 2. Consideration should be given to approaching safety in relation to non-tidal waters in the same or similar way that tidal waters are dealt with. Whilst some proportionality will of course be required, it may be that there is some predictability to areas of particular danger in inland waters, for instance where these are regularly used by members of the public (as was the case here), and with reference to weather, and bank holidays.
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 21st January 2022. 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 Jordan's family. 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. I will also send a copy of this report to the Maritime Volunteer Service, Royal National Lifeboat Institution and Royal Life Saving Society. For the avoidance of doubt, I only require formal responses from the Environment Agency and the National Trust.
9	**26th November 2021**  **Mrs Heidi J. Connor** **Senior Coroner for Berkshire**