GRAEME HUGHES

HER MAJESTY'S
SENIOR CORONER

SOUTH WALES CENTRAL
CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW

Telephone: [redacted]
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ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive Brecon Beacons National Park Authority** **Chief Executive Natural Resources Wales** **Chief Executive Neath Port Talbot Council** **Chief Executive Powys County Council** **Chief Executive Rhondda Cynon Taf County Borough Council**
1	**CORONER** I am **Rachel Knight Assistant Coroner**, for the coroner area of South Wales Central.
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.

[redacted] [redacted]

3	**INVESTIGATION and INQUEST** On 24 August 2021 I commenced an investigation into the death of Hemanta Kumar RAI. The investigation concluded at the end of the inquest on 19/07/2022. The conclusion of the inquest was Accident. **1a Drowning** **1b** **1c** **II**
4	**CIRCUMSTANCES OF THE DEATH** Hemanta Kumar Rai was aged 28 when he was visiting South Wales on holiday in the summer of 2021. On 16th August, together with a friend, he entered the area of a deep waterfall at Pontneathvaughan, Powys. A strong current pulled Hemanta, who was not a swimmer and was merely paddling, under the water towards the waterfall, and tragically, despite the efforts of friends and emergency services, he drowned.
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) There is no adequate signage to warn visitors of the risk of drowning by entering the water at Sgwd Gwladys. (2) Existing signage in 'Waterfall Country' is overloaded with a variety of information, which although helpful for walking routes etc, is not explicit in warning of the real danger of death from entering the water. (3) Any sign(s) erected ought to be easily visible, in plain English and spell out the risk of death by drowning. (4) It is very unclear who bears responsibility for this particular area, which borders 3 local authority areas, and falls within the National Park and NRW jurisdiction.
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.

[redacted] [redacted]

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20th September 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 family of Mr Rai who may find it useful or of interest. 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	26 July 2022 **SIGNED:**  Rachel Knight Assistant Coroner for South Wales Central Coroner Area