GRAEME HUGHES

HIS MAJESTY'S
SENIOR CORONER

SOUTH WALES CENTRAL
CORONER AREA

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

[redacted]

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:** **Brecon Beacons National Park Authority;** **Rhondda Cynon Taff CBC;** **Neath Port Talbot Council;** **Powys County Council; and** **Natural Resources Wales**
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.
3	**INVESTIGATION and INQUEST** On 15 June 2021 I commenced an investigation into the death of Akeem Jevaughn RHODEN . The investigation concluded at the end of the inquest on 29th November 2022. The conclusion of the inquest was misadventure. The cause of death was recorded as: **1a Drowning** **1b**

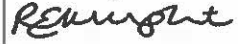
[redacted]

[redacted] [redacted]

	1c II
4	**CIRCUMSTANCES OF THE DEATH** **Akeem Jevaughn Rhoden was aged 22 when he voluntarily jumped off a rock into the water at Sgwd Y Pannwr Waterfall, Brecon Beacons, near Pontneddfechan on 5th June 2021. He was not a strong swimmer and he drowned due to the force of the water. His body was recovered on 6th June 2021, having been trapped under a ledge.**
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 signage at ALL waterfalls in 'Waterfall Country' must be addressed; (2) Akeem Roden was not a strong swimmer and there were no adequate signs at the point he jumped in to warn him of the potential dangers and that he might drown; (3) Signage at each waterfall should be in plain, bold, easily understandable English, spelling out the danger of the power of the water; and (4) Existing signage is overloaded with information and not present at the point where individuals may decide to enter the water.
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 7th February 2023. 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. I would welcome a joint response, as the ownership of the various waterfalls is less than clear, but the problem is the same for each of them.

[redacted]

[redacted] [redacted]

8	**COPIES and PUBLICATION** I have sent a copy of my report to Mr Rhoden's family 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	13 December 2022 **SIGNED:**  Rachel Knight Assistant Coroner for South Wales Central Coroner Area

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