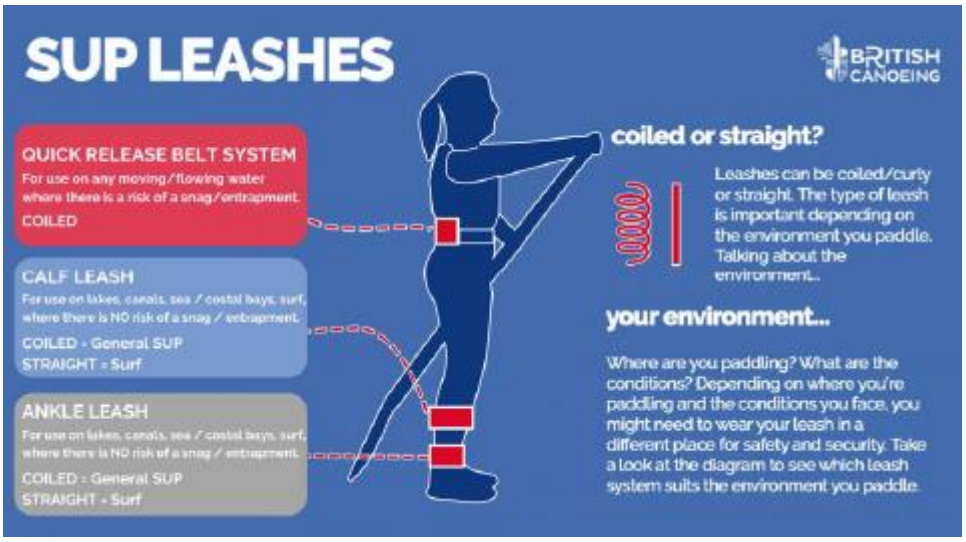
John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. His Majesty's Government c/o Prime Minister's Office, 10 Downing Street, London SW1A 2AA **2.** Tesco PLC, Tesco House, Shire Park, Kestrel Way, Welwyn Garden City, Hertfordshire AL7 1GA
1	**CORONER** I am John Adrian Gittins, Senior Coroner for North Wales (East and 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 the 16th Of July 2022 I commenced an investigation into the death of Emma Louise Powell (DOB 22.10.97 DOD 15.7.2). The investigation concluded at the end of the inquest on the 8th of December 2022. The conclusion of the inquest was that the death was the result of an accident, the cause of Miss Powell's death being recorded as 1(a) Immersion
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows : On the 14th of July 2022 at Conwy Morfa, the deceased got into difficulties whilst paddleboarding. The current of the Spring tide resulted in her being unable to make her way to safety and she was recovered from the water after being submerged for a period in excess of ten minutes. She was taken to Ysbyty Gwynedd where her death was confirmed shortly after midnight on the 15th of July.
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. – The evidence at inquest indicated that Miss Powell had purchased a paddleboard from Tesco at Llandudno Junction on the evening of the 14th of July 2022, that she had taken it to Conwy Morfa and had thereafter used it in an unsafe manner, whereby she did not wear any life saving equipment and the safety leash on the board was by way of an ankle leash which was inappropriate for the fast flowing water.

	The evidence further indicated that at the point of sale, there was no safety advice or guidance provided in relation to either the advisory wearing of a safety vest, or the need to be aware that the positioning of a safety leash should take into account the environment/water conditions where the paddleboard is to be used as per the below information:  Unless action is taken to improve the provision of information to purchasers of paddleboards and/or to regulate the sale of paddleboards to ensure that the provision of advice of this nature becomes a mandatory requirement at the point of retail sale, then there is an ongoing risk that further accidents will occur and that lives may be lost as a result.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 22nd of 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Family of the Deceased and to the Chief Coroner. 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	Dated 28th December 2022 Signature Senior Coroner for North Wales (East and Central)