Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], Chairman of Trustees, The Forest of Marston Vale Trust**
1	**CORONER** I am Emma WHITTING, Senior Coroner for the coroner area of Bedfordshire and Luton Coroner Service
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 05 August 2022 I commenced an investigation into the death of Kyron Marcus HIBBERT aged 13. The investigation concluded at the end of the inquest on 26 January 2023. The conclusion of the inquest was that Kyron died as result of **Misadventure**.
4	**CIRCUMSTANCES OF THE DEATH** During a heatwave whilst spending time with friends at Stewartby Lakes near Marston Moretaine on 29 July 2022, the Deceased, who was unable to swim, at around 18.30 hours, decided to have a turn on the rope swing that was attached to a tree at the lakeside and which the others had been using to enter the water. He took off his shoes, socks and t-shirt and pushed his jogging trousers down to his ankles and, after being swung over the water for a second time, he released hold of the rope and entered the water. He immediately struggled to find his footing or tread water owing to a combination of the depth and coldness of the water as well as the restriction of his trousers. His friends were unable to take hold of him and he quickly became submerged. Emergency services were alerted and after extensive searches he was recovered from the water; his death was confirmed by paramedics at 02.25 hours on 30 July 2022.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) At the Inquest hearing, The Forest of Marston Vale Trust ('the Trust') stated that since Kryon's death they had taken no further action to address the risks of children drowning at Stewartby Lakes. However, it was clear from the evidence provided that: (1) The specific location where the incident occurred was well known to local children; the Head Ranger also admitted that this location, known as 'Location 5' along with 'Location 7' was known as an area where people would/could enter the water (albeit that

	there were signs at both locations indicating that swimming was prohibited). Furthermore, during the recent heatwave, (albeit this was not known to the Trust) local children had been regularly going to Location 5 and using a rope swing they knew to be located there (2) On Friday 29 July 2022, children had been present at the location using the rope swing since at least 2pm and yet their presence and/or the presence of the rope was not discovered - whilst Rangers do check all areas of the park, including Stewartby Lake this is only incidental to their other duties on any given day and checks are not increased around the lake during hot weather (Head Ranger's evidence); (3) At the location where the incident occurred, there are varying depths of water but (other than the general 'No Swimming' Safety Boards) there was no indication of these relative depths provided to visitors. Investigating police observed that there is a ledge of the lake that was waist height on the children (this was seen the video footage taken by the the children on the day of the incident) and that this shallow ledge drops away suddenly into deep water which is believed to be 13 metres deep. It was believed that Kyron had fallen beyond the edge of the shallow area. (4) At the time of the incident, safety/life-saving equipment at the location of the incident was limited to a Safety Board consisting of a throwline in a locked box which required a code from Emergency Services (necessitating a 999 call) to release it. The Head Ranger explained that the previous life safety rings (costing approx. £40.00 each) had not been replaced once the locked throw lines had been installed. The locked throw line was not accessible to the children; although, they had seen the Safety Board as they had approached Location 5 and noted that there was some kind of float inside it, when they had gone to access it when Kyron went into the water they couldn't get the code as their phone battery had died. They reported that the box (Safety Board) "*felt very far away from where we were down at the water*" . Although since the Inquest, the Trust have indicated that in addition to the locked throw lines on the Safety Boards, traditional safety lines are also to be installed again at Locations 5 and 7; I am concerned that these are to be placed next to the Safety Boards rather than closer to the lakeside. Whilst prompt access to further life-saving equipment may not have altered the outcome in this incident, it might in future incidents.
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 April 24, 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 Chief Coroner. I have also sent it to **Royal Life Saving Society (RLSS)** **Red Hill House, 227 London Rd, Worcester. WR5 2JG** **Central Bedford Safeguarding Children Board (CBSCB)** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all

	interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 27/02/2023** **Emma WHITTING** **Senior Coroner for** **Bedfordshire and Luton Coroner Service**