REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Foreign, Commonwealth and Development Office 2) ABTA – The Travel Association
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 14th July 2022 I commenced an investigation into the death of Sandra Curran. The investigation concluded on the 5th June 2023 and the conclusion was one of **Accidental Death**. The medical cause of death was **1a) Apshyxia; 1b) Drowning**
4	CIRCUMSTANCES OF THE DEATH On 4th July 2022, Sandra Curran was snorkelling in the sea adjacent to the beach in Bugibba Saint Paul's in Malta. Concerns were raised about her appearing to be no longer moving. She was brought to the beach where she was unresponsive. An investigation in Malta found she had died from asphyxia as a consequence of drowning.
5	<u>CORONER'S CONCERNS</u> 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 inquest heard the Mrs Curran had booked her holiday through a UK Tour operator. Mrs Curran was not a strong swimmer and that she was unaware of the risks that swimming/snorkelling in the sea off the coast of Malta could present. No warnings were given in the welcome information/briefing about the challenge the sea around the coast in Malta could present to a weak swimmer. Previously when she had snorkelled it had been in far easier conditions where

	the risks of strong currents had not been present. The evidence given by her family at the inquest was that had her tour operator highlighted the need for caution Mrs Curran would not have snorkelled alone in the area where she drowned. A more proactive approach by UK tour operators highlighting the risk of getting into difficulties and how to mitigate them would reduce the risk of further deaths in circumstances such as Mrs Curran's.
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 **4th December 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 and to the following Interested Persons namely [redacted] on behalf of the 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	**Alison Mutch** **HM Senior Coroner**  **09.10.2023**