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:** **The Chief Executive of the Coal Authority**
1	**CORONER** I am David Regan, 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** A Coronial investigation was commenced on 8th July 2019 into the death of Christopher Grace Kapessa. The Investigation concluded at the end of the inquest which I conducted on 8th – 22nd January 2024. The conclusion was a narrative conclusion and the medical cause of death was 1 (a) submersion
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as: - Christopher Kapessa, aged 13, attended the Red Bridge at Abercwmboi in the afternoon of 1st July 2019, meeting a group of school friends of largely the same age, some of whom intended to jump into the water. Christopher took with him clothes in which he could swim, undressed to his shorts and approached the water side. He had not decided whether to enter the water and was expressing both a desire to swim and concern due to his limited ability to swim. At about 17.25, while he was standing by the water side looking in to the river, he was deliberately pushed in to the water by another child, falling 2.5 metres to the water surface. There was a current. The water was cold and too deep for him to touch the bottom and keep his head above the surface. Christopher was swiftly in difficulty, thrashing ineffectively with his arms. Children, including

	the boy who had pushed him, jumped in to the water to try to save him, but were unable to do so. He became submerged. Some of the children sought help and the emergency services attended and carried out a search, finding Christopher underwater at about 19.25. Resuscitation attempts took place but after so long a period submerged, Christopher could not be saved. The narrative conclusion which I returned was: Christopher Kapessa, aged 13, died by submersion when intentionally pushed by another child into the river Cynon. The push was a dangerous prank. However, the child responsible for it did not intend to cause Christopher's death and himself jumped into the water with other children in an unsuccessful attempt at rescue. The Inquest focused upon: - a. The circumstances in which Christopher came to enter the water at the "Red Bridge", Abercwmboi b. The response of the emergency services to reports of the incident c. What was known by the Coal Authority, being the occupier of the bridge from the vicinity of which Christopher entered the water, and the authorities responsible for public safety, as to whether the site was used for swimming by children, and whether any steps were or ought to have been taken to prevent such activity or warn or safeguard those undertaking them.
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 Coal Authority was aware that members of the public used the site for purposes including recreational walking. The Court found that the site was known by children as a site from which to swim, but that this was unknown to the Coal Authority. Nevertheless, Coal Authority documentation was not easily cross referenced or accessible to inspectors to ensure that any reports that might be made with respect to activities by members of the public who might put themselves at risk were available to inspectors when conducting safety inspections.

	(2) No specific water safety policy relating to risk assessment or the provision of safety equipment was in place, or is currently in place. (3) The annual inspections conducted by the Coal Authority were limited in content, unclear in format and identified no clear criteria to be used for the basis of decision making. (4) Inspectors were not provided with any guidance as to how to assess whether members of the public accessing the site should be safeguarded from the risks of deep and fast flowing water, and if so how. No signage was in place to warn of the specific dangers of deep and fast flowing water. No consideration was given as to whether equipment to assist in the rescue of members of the public who may have got into difficulty, such as throw lines, should be provided. (5) Remedial work was identified to remedy aspects of the site which rendered it unsafe, but were not carried out. No system appeared to be in place to ensure that such works were carried out following inspection.
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 20th March 2024. 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 family who may find it useful or of interest. Welsh Government, the National Water Safety Forum, Rhonda Cynon Taf County Borough Council 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	**24th January 2024** **SIGNED:**

	D Regan **Assistant Coroner**