	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive Officer, NEATH PORT TALBOT COUNCIL** **2. [redacted], Chief Executive Officer, ASSOCIATED BRITISH PORTS** **3. [redacted], ROYAL NATIONAL LIFEBOAT INSTITUTION**
1	**CORONER** I am EDWARD RAMSAY, His Majesty's Assistant Coroner for the coroner area of SWANSEA AND NEATH PORT TALBOT.
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 24 June 2023 the Senior Coroner commenced an investigation into the death of DAVID CHIAKA EJIMOFOR aged 15 (hereafter "DAVID"). The investigation concluded at the end of the inquest held between 19 - 21 MAY 2025 before me sitting alone in the Swansea Coroner's Court. Box 2 of the Record of Inquest recorded that DAVID'S medical cause of death was "*1a) consistent with drowning*". Box 4 of the Record of Inquest recorded a conclusion of *Misadventure*.
4	**CIRCUMSTANCES OF THE DEATH** Box 3 of the Record of Inquest recorded that DAVID died: "*At 2005 on 19 June 2023 at the little beach at Aberavon having drowned after jumping into the sea from the breakwater, to which he had, effectively, unrestricted and undeterred access. The breakwater should not have been used for that purpose but was known to have been used for that purpose by local children and teenagers, especially in the spring and summer months when the weather was good and the tides were high. In the past lifeguards had been stationed at or around the pier, at these times, to deter this activity. No lifeguard was present at the time that David jumped. Had there been one it is possible that David would not have jumped and therefore would not have drowned".*
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 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. – (1) There are no lifeguards stationed at the breakwater during higher risk periods in the spring and summer months (when the weather is good and the tides high), when children and young people have been seen/known to jump into the water from it. (2) Jumping from, and the water around, the breakwater is known to be dangerous. (3) The practice of placing a lifeguard at the breakwater at times of higher risk in the spring and summer months (when the weather is good and the tides high) had been in place historically and was known to be effective at reducing the risk. (4) I was not given, in evidence, a satisfactory or cogent explanation as to why that measure had been removed prior to DAVID's death, nor why that measure continues to be absent today.

	(5) Nor was I shown any evidence that other deterrence measures put in place since DAVID's death (including clearer signage and a limited-height barrier) are otherwise working effectively to reduce the risk.
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 **30 JULY 2025**. 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: (1) DAVID'S family (2) Neath Port Talbot Council (3) Royal National Lifeboat Institution (4) Associated British Ports (5) HM Coastguard 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 other 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.
9	**4 June 2025**  **EDWARD RAMSAY** ASSISTANT CORONER FOR SWANSEA AND NEATH PORT TALBOT