

GRAEME HUGHES
HIS MAJESTY'S
SENIOR CORONER

SOUTH WALES CENTRAL
CORONER AREA



CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW

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: TUI UK Limited Association of British Travel Agents (ABTA)
1	CORONER I am Gavin Knox HM 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

	On 25 June 2019 I commenced an investigation into the death of Theo Phillip TREHARNE-JONES . The investigation concluded at the end of the inquest on 15 October 2025. The conclusion of the inquest was Accident. 1a Drowning 1b 1c II
	CIRCUMSTANCES OF THE DEATH These were recorded as :- 4 Theo Treharne-Jones died on 15 June 2019 by drowning in a swimming pool at The Holiday Village Atlantica, in Kos Greece where he was on holidays with his family. Theo was 5 years old. He could not swim and as a result of a genetic condition had no sense of danger. He accessed the swimming pool, which had no protective barrier, after leaving his hotel room unnoticed while his parents were asleep. The hotel room locks were of a design that did not secure against Theo leaving the room.
	<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. Theo was particularly vulnerable in that: 5 1. He had developmental delay; 2. He had no sense of danger; 3. He was prone to waking during the night; 4. He was fully mobile; 5. He loved swimming and had some sensory needs; 6. He was unable to swim. The door locks in the hotel room were of a design to promote safety during a fire and could be easily disengaged from the inside; There was no secondary security measure such as a chain in place; Theo's parents recognised the risk of Theo leaving the room unsupervised and attempted to



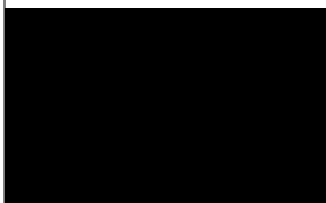
	mitigate this by locking the door and putting additional impediments in the way of the door including 2 pushchairs and an empty suitcase; ABTA guidance does make reference to a security chain/latch but this is the context of enabling customers to identify a visitor at the door and merely states such <i>could</i> be provided. However, there is no reference in the guidance to any form of security in the sense of controlling the exit from the room. No specific information about door locks and security chains was given to Theo's parents on booking or on arrival. The pool that Theo was found in did not have any physical barrier in place to prevent uncontrolled or unsupervised access by children.
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 12th December 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 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. She may send a copy of this report to any person who she 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.



16 October 2025

SIGNED:

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Gavin Knox HM Coroner for South Wales Central Coroner Area

Coroner's Office, The Old Courthouse, Courthouse Street, Pontypridd, CF37 1JW

Phone/Ffôn (01443) 281100

Fax/Ffacs (01443) 485862