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 WIGMORE HOUSE WIGMORE LANE LUTON BEDFORDSHIRE LU2 9TN
1	**CORONER** I am **Aled Gruffydd**, Assistant Coroner, for the coroner area of SWANSEA 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 22nd July 2025 an investigation was commenced into the death of Leslie Keith Williams. The investigation concluded at the end of the inquest on 21st May 2026. The medical cause of death is 1a drowning 1b) pure autonomic failure The conclusion of the inquest as how Mr Williams came to his death is a narrative conclusion and is as follows:- - The deceased died from drowning after losing consciousness in the sea due to the naturally occurring condition of pure autonomic failure.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Leslie Keith Williams, who was pronounced dead on the 1st of July 2025 at the Jasmine Hospital, Hurghada, Egypt. Keith and his wife [redacted] were holidaying at the TUI Blue Crystal Resort in Hurghada. After breakfast Keith stated that he wanted to walk down to the sea a short distance away. Keith suffered with PAF (pure autonomic failure) which is a rare neurodegenerative condition that affects the autonomic nervous system with the most common feature being orthostatic hypotension, which is a significant drop in blood pressure when you stand up. This meant he was also prone to falling unconscious.

	A short while after he had left, [redacted] decided to walk down to the beach and find him. As she was walking towards the sea she saw that Keith was being pulled out of the water by a lifeguard and a passerby. Not long after two British nurses who were on the beach also arrived and began providing CPR. [redacted] states that it took 40 minutes before a Doctor arrived at scene and it was 15 minutes before a defibrillator came from the hotel. Keith was conveyed to hospital and was pronounced deceased a short time later.

5	**CORONER'S CONCERNS** During the inquest evidence was heard that it took 15 minutes for a defibrillator to arrive and 40 minutes for a doctor to arrive. Despite CPR attempts being made by lifeguards and holidaying nurses these lifesaving measures were not present. I was also told by the wife of the deceased that this was the third case of drowning at the 'resort'. However, I do not have verification of this information and do not know the exact location of these other possible drownings. It is acknowledged that TUI UK are not the direct owners of the hotel however it is understood that it comes under the 'TUI Blue' brand. The **MATTERS OF CONCERN** are as follows. – 1. That lifesaving measures beyond basic CPR are delayed thus reducing the opportunities for a successful outcome. 2. These prevailing circumstances have led to this incident being the third drowning incident at the resort.
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 21 July 2026. 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 [redacted]. 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. They may send a copy of this report to any person who they believe 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	 **21 May 2026…** **…. [SIGNED BY CORONER]**