# **DAC BEACHCROFT**

18 April 2023

HM Senior Coroner for Bedford and Luton The Court House Woburn Street Ampthill Bedford

Sent by email only

Dear Madam

#### Kyron Hibbert Deceased

As you will be aware from our previous correspondence we act on behalf of Forest of Marston Vale Trust (the "Trust") to whom you issued a Regulation 28 report dated 27<sup>th</sup> February 2023 following the inquest into the death of Kyron Hibbert held on 26<sup>th</sup> January 20223. Please treat this letter as our client's response to your Regulation 28 report. This response has been reviewed and approved by the Directors of the Trust.

Our client's responses to the "Matters of Concern" raised by H M Senior Coroner are set out below. For ease of reference H M Senior Coroner's comments are italicised and emboldened.

#### "At the Inquest hearing, The Forest of Marston Vale Trust ('the Trust') stated that since Kyron's death they had taken no further action to address the risks of children drowning at Stewartby Lakes."

At the inquest the Head Ranger of the Trust was asked whether any changes had been made as a consequence of this accident. She confirmed they had not .In our written submissions to HM Senior Coroner dated 7<sup>th</sup> February 2023 we confirmed ;

"The Trust had a duty under Regulation 3 of the Management of Health and Safety Regulations 1999 to review its risk assessment and safety arrangements in the light of Kyron's death. The Trust carried out this review and its conclusion was that the risk assessment in place at the time of the incident met the legal duty under Regulation 3 in that it was both suitable and sufficient. Having reviewed matters the Trust decided to continue with the roll out of the new safety boards around the lake after Kyron's death. "

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It follows that the action taken by the Trust after the incident was in accordance with its obligations under the prevailing health and safety legislation.

*"However, it was clear from the evidence provided that:* (1) The specific location where the incident occurred was well known to local children; the Head Ranger also admitted that this location, known as 'Location 5' along with 'Location 7' was known as an area where people would/could enter the water (albeit that there were signs at both locations indicating that swimming was prohibited). Furthermore, during the recent heatwave, (albeit this was not known to the Trust) local children had been regularly going to Location 5 and using a rope swing they knew to be located there

).

The Head Ranger confirmed in evidence , which was in line with the content of documentary evidence supplied to H M Senior Coroner prior to the inquest, that the Trust was aware of certain locations where on occasions members of the public had been seen to enter the lake. The documentation supplied to H M Senior Coroner prior to the inquest confirmed the extensive efforts that had been made to dissuade people from doing this by reference to physical barriers, warnings/information and the provision of safety equipment . Safety measures taken on site were supplemented by messages to the local community on social media.

### (2) On Friday 29 July 2022, children had been present at the location using the rope swing since at least 2pm and yet their presence and/or the presence of the rope was not discovered (**Construction** - whilst Rangers do check all areas of the park, including Stewartby Lake this is only incidental to their other duties on any given day and checks are not increased around the lake during hot weather (Head Ranger's evidence);

The Trust's efforts have always been focussed on preventing people from entering the lake. Suitable warnings are in place at all public entrances to the park and at various points around the lakeside perimeter path. It is highly significant that all of the children confirmed they were aware they should not swim in the lake. Kyron, very sadly, had been given a specific warning from his mother that he could well drown if he entered the water.

The sheer size ,topography and restricted sight lines render routine visual checks impracticable and ineffective.

(3) At the location where the incident occurred, there are varying depths of water but (other than the general 'No Swimming' Safety Boards) there was no indication of these relative depths provided to visitors. Investigating police observed that there is a ledge of the lake that was waist height on the children (this was seen the video footage taken by the the children on the day of the incident) and that this shallow ledge drops away suddenly into deep water which is believed to be 13 metres deep. It was believed that Kyron had fallen beyond the edge of the shallow area.

The Trust has not seen the video footage referred to but is aware of this issue at very many points around the lake . This is one of several reasons why entering the water is forbidden . The risk of "Hidden Hazards" is specifically identified on safety signage around the lake. As indicated in our written submission the Trust's view is that placing signs in the very many deep water areas will create the impression that those areas that not signed are somehow safe for swimming.

It is important to note in this respect that the Internal Drainage Board is the public body responsible for surface water management in the entire Marston Vale and specifically responsible for the management of water levels in Stewartby Lake in its use as a strategic stormwater balancing facility. This function entails that there can be a 0.75m variation in depth throughout the year. This depth variation translates into a significant encroachment into shoreline.

(4) At the time of the incident, safety/life-saving equipment at the location of the incident was limited to a Safety Board consisting of a throwline in a locked box which required a code from Emergency Services (necessitating a 999 call) to release it. The Head Ranger explained that the previous life safety rings (costing approx. £40.00 each) had not been replaced once the locked throw lines had been installed. The locked throw line was not accessible to the children; although, they had seen the Safety Board as they had approached Location 5 and noted that there was some kind of float inside it, when they had gone to access it when Kyron went into the water they couldn't get the code as their phone battery had died. They reported that the box (Safety Board) "felt very far away from where we were down at the water" ). Although since the Inquest, the Trust have indicated that in addition to the locked throw lines on the Safety Boards, traditional safety lines are also to be installed again at Locations 5 and 7; I am concerned that these are to be placed next to the Safety Boards rather than closer to the lakeside. Whilst prompt access to further life-saving equipment may not have altered the outcome in this incident, it might in future incidents.

The Head Ranger's evidence at inquest was that locked throw lines in a number of locations had replaced unlocked throw lines, not life rings. There were therefore a combination of locked and unlocked throw lines around the lake at the time of this incident. The design of the locked throw lines was arrived at following consultation with Bedfordshire Fire and Rescue and reflects that used by the local authority in the Bedford area. The locked line was accessible to the children if one of them had followed the instructions on the signage to obtain the access code from the emergency operator. The written evidence on the issue was that one of the children had no battery power in her phone. It is highly likely others had mobile phones that were working. It seems reasonable to infer from the evidence that the fact that Kyron , a non-swimmer, immediately went under the water and did not resurface meant the children were not seeking rescue equipment.

The Trust has looked at installing additional unlocked throw lines in areas where there are secure lines in place. It has also considered whether these can be located closer to the edge of the lake .The locked lines are on the main lakeside walkway where they are most visible to members of the public. As has been highlighted in evidence and previous written submissions, the water level of the lake varies significantly throughout the year as the lake is part of the flood defences in the area. We have described the role of the IDB in response to point 3 above. To illustrate the impact of this on the shoreline we attach two photographs taken in March 2023 showing the general area where this incident occurred . It can be seen that the area where the children were playing is completely under water.

Whilst it is not accepted the secure throw lines were "very far away" from the water , in order to deal with HM Senior Coroner's concern on this issue the Trust will install additional unlocked lines closer to the high water mark of the lake at locations 5 and 7 , and at the other points around the lake and closer to the edge of the lake in locations where there have been previous incidents of swimming.

These new throw lines with accompanying safety signage will be in place by 1<sup>st</sup> June 2023.

All at the Trust was devastated by Kyron's death and it will go above and beyond its legal duty to try and avoid a similar incident. That said the Trust believes the evidence in this case sadly confirmed the positioning or availability of life saving equipment would not have altered the fatal outcome of this case.

As well as installing the new throw lines and signage referred to above, the Trust has resolved to issue messages to local schools in periods of warm weather warning of the dangers of accessing the lake, and encouraging them to share this information with their pupils. This will supplement information already provided by the Trust via social media.

Yours faithfully

Partner DAC Beachcroft

### **Gullwatch - Other**



## Gullwatch 2- from top of bank down to edge. - Other

