REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

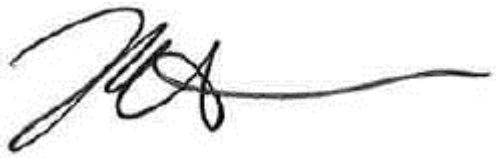
*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. National Coasteering Charter**
1	**CORONER** I am Brendan Joseph Allen, Area Coroner, for the Coroner Area of Dorset
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 the 30th May 2019, an investigation was commenced into the death of Iain Richard Farrell, born on the 20th April 1970. The investigation concluded at the end of the Inquest on the 29th September 2023. The Medical Cause of Death was: 1a Drowning 1b 1c 2 The conclusion of the Inquest recorded that Iain Richard Farrell died as a consequence of misadventure in circumstances where he inhaled sea water after he had become breathless during a swim. After having been extracted from the sea onto a ledge by the instructor, a large wave swept him back into the water. This occurred in a challenging sea state during a led coasteering experience. Prior to starting the activity, Mr Farrell had expressed that he was not a confident swimmer.

4	**CIRCUMSTANCES OF THE DEATH** On 26th May 2019 Mr Farrell took part in a led coasteering activity at Hedbury Quarry with his two sons, [redacted], and 6 other participants, two of which were also children. None of the group had previous experience of coasteering. Mr Farrell was not a confident swimmer. The group was led by a single experienced freelance coasteering guide, [redacted], working for Land and Wave, a local outdoor activities provider. Hedbury Quarry is a remote location off the South West Coast Path. It is approximately a 20 minute walk from the nearest carpark. It is known that there is no phone signal along this particular stretch of the coastline. The guide was equipped with safety items, including a floating rope. In a "safety bag", which was left in a central location on the coasteering route, was further safety equipment, including a VHF radio. The sea state on 26th May 2019 was challenging at the start of the session and this became worse as the session progressed. At the start of the session the coasteering group were asked to jump into the water from a sea ledge, assisted by the coasteering guide. They were instructed to swim away from the rocks and form a safety raft, before swimming in a westerly direction. During the swim, Mr Farrell became breathless and exhausted. The guide stayed with Mr Farrell to encourage and support him and subsequently made the decision to lead Mr Farrell to the shore with a view to getting him out of the water and cancelling the session. The rest of the group were instructed to form a safety raft and remain in the sea. The guide used a length of "floating rope" to tow Mr Farrell to a sea ledge from which they would both be able to leave the coastline. However, once Mr Farrell had managed to climb onto the ledge with the guide, both were swept back into the sea by a large wave. It is likely that, at this point, Mr Farrell inhaled sufficient sea water to begin the process of drowning. Minutes later he became unresponsive in the sea.

	The guide recovered Mr Farrell to a sea ledge and began CPR. He was unable to make his way to the rescue bag. The remaining coasteering group, who were now drifting further out to sea and westwards, were able to attract the attention of climbers at Hedbury Quarry, who were, in turn, able to access the rescue bag and raise the alarm using the VHF radio. HM Coastguard were contacted approximately 15 minutes after Mr Farrell became unresponsive in the water. The emergency services, including the RNLI, HM Coastguard, South Western Ambulance Service and the Police attended the scene. Despite resuscitation efforts, Mr Farrell was confirmed deceased. There is no regulatory body for coasteering, but written guidance is provided by the National Coasteering Charter ("NCC"). The current guidance was issued in 2015. Coasteering providers and guides are not obliged to follow the guidance, though a significant number of providers and guides are NCC members.
5	**<u>CORONER'S CONCERNS</u>** The **MATTERS OF CONCERN** are as follows: 1. During the inquest evidence was heard that: i. There are risks associated with lone guiding when coasteering, including the risks of the guide becoming incapacitated and/or a participant becoming incapacitated and requiring the attention of the sole guide, leaving the remainder of the group without support. ii. A second guide on this coasteering experience may have been able to assist with the following: raising the alarm sooner; assisting and supporting the remaining coasteering participants, which included four children, who were in the water in increasingly challenging conditions for nearly two hours before being rescued by the RNLI All Weather Lifeboat. iii. The VHF radio, the sole means of communication and raising the alarm, was in rescue bag on the shore, in a central location. A VHF radio carried by the guide or within immediate reach would have enabled the raising of the alarm with no delay.

	iv. There was no assessment of swimming ability or water confidence during the booking process for coasteering, which may have given an indication to Mr Farrell about the full nature of the experience, nor was he asked about his physical fitness. 2. I have concerns with regard to the following: i. There are specific risks associated with "lone guiding" in coasteering, as detailed above. Highlighting these risks in NCC guidance will assist coasteering providers and guides in formulating effective and practical risk assessments to mitigate those risks; ii. Given the risks associated with lone guiding, consideration should be given to the NCC guidance promoting that two guides should be the minimum allocated to any coasteering group. Where a provider departs from the guidance and allocates a single guide, they should be directed to ensure they can demonstrate additional safety measures they have adopted to mitigate the risks associated with lone guiding, including but not limited to how the safety needs of the participants are met if the guide becomes incapacitated, or if a participant becomes incapacitated requiring the full attention of the guide. iii. Consideration should be given to the NCC guidance making it clear that a lead guide should have with them, or within immediate reach, access to a means of communication with which to summon the emergency services, for example a mobile phone, or where there is known to be no mobile phone reception, a VHF radio. iv. At the time of booking a coasteering experience, the nature and potential physical demands of the experience at the coasteering location proposed should be made clear and a prospective participant should be asked about their swimming ability and physical fitness.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, so by 8th December 2023. 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) Optimal Solicitors (representing Mrs Farrell and their sons); (2) [redacted] brother of Iain Richard Farrell; (3) [redacted], sister of Iain Richard Farrell; (4) [redacted], sister of Iain Richard Farrell; (5) DAC Beachcroft Solicitors (representing [redacted], the coasteering guide); (6) HCR Solicitors (representing Land and Wave, the coasteering provider; (7) Dorset Council. I have also sent the report to the following: (1) Royal National Lifeboat Institute; (2) Royal Society for the Prevention of Accidents; (3) Maritime and Coastguard Agency; (4) Royal Life Saving Society UK; (5) Surf Life Saving GB; (6) Adventure Activities Licencing Authority; (7) Adventure Activities Licencing Service; (8) Adventure Activity Industry Advisory Committee; (9) Health and Safety Executive. 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	**Dated** 13th October 2023	**Signed**  **Brendan J Allen**