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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr A Chisholm, Permanent Secretary (Cabinet Office)**
1	**CORONER** I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 31/1/24, I concluded the inquests into the deaths of: i) Michael Pender, who drowned at Treyarnon beach on 25/5/20; ii) Jan Klempar, who drowned at Porthcurno beach on 25/6/20; iii) Paul Mullen, who drowned at Church Cove on the Lizard on 20/8/20. The three inquests were heard together as they arose out of a common occurrence namely that, following the relaxation of the national lockdown after the COVID-19 pandemic, they all happened on beaches that would ordinarily have been lifeguarded but were not at the material times. A copy of my judgment is attached.
4	**CIRCUMSTANCES OF THE DEATH** i) Mr Pender drowned at Treyarnon beach on 25 May 2020. He lived locally. At the time, the country had just come out of lockdown after the emergence of the COVID-19 pandemic. Lifeguards would ordinarily have been present on the beach but, on that date, were not. Additional signage had been put up and there had been an extensive media campaign to alert the public to the position. Mr Pender was seen to get into difficulty. He was found floating in the water and taken to Padstow lifeboat station where he was confirmed deceased. ii) Mr Klempar drowned at Porthcurno beach on 25 June 2020., having travelled down from the Midlands for the day with his

	family. At the time, the country was still coming out of lockdown after the emergence of the COVID-19 pandemic. Lifeguards would ordinarily have been present on the beach but, at the time of the incident, were not. Additional signage had been put up and there had been an extensive media campaign to alert the public to the position. Mr Klempar was seen to get into difficulty. He was found floating in the water and recovered to the beach. Efforts to resuscitate him were unsuccessful. iii) Mr Mullen drowned at Church Cove on the Lizard on 20 August 2020. He was on holiday with his family. At the time, the country was still coming out of lockdown after the emergence of the COVID-19 pandemic. Lifeguards would ordinarily have been present on the beach but, at the time of the incident, were not. Additional signage had been put up and there had been an extensive media campaign to alert the public to the position. The sea was unusually rough due to an approaching storm. Mr Mullen went into the sea after his son got into difficulties. He was found floating in the water and recovered to the beach. Efforts to resuscitate him were unsuccessful.
5	**CORONER'S CONCERNS** During the course of these inquests, the evidence has 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** fall into two broad areas: **COVID-19 related concerns** i) The government took the decision to offer furlough to those in receipt of PAYE as at the end of February 2020. Most of the c1600 lifeguards who work on the 250 beaches where the RNLI are present are seasonal employees. They did not qualify for furlough. At that point in time, the RNLI was in the process or recruiting and training the seasonal lifeguards it required. When furlough was not offered, a number had to seek alternative means of income. As lockdown was eased and lifeguards were required, the RNLI did not have immediately available to it the seasonal employees it required to provide beach safety around the coast.

I found this contributed to the problems that ensued in a partial sense. I do not suggest that had the seasonal lifeguards been furloughed all of the difficulties could have been avoided. The evidence revealed some lifeguards may not have wanted to take up their position in light of COVID and there were additional complications like how new lifeguards became formally qualified when providers were not available as well as how the RNLI could have provided COVID secure places of work in the time available;

ii) The lack of advance notice given to the RNLI of government's intention to relax lockdown and allow people to travel to the beach again. The RNLI anticipated the difficulties developing. It wrote to the Department of Transport and the Prime Minister to make sure the relevant people were aware of the problems. By letter of 24 April 2020, Kelly Tolhurst MP, Minister for Aviation, Maritime & Security informed the RNLI Chief Executive that: 'Officials will ensure RNLI is notified as far in advance as possible to enable you to mobilise your assets as appropriate.' That did not happen. The RNLI learned of the decision to relax lockdown at the same time as the general public and was put in an impossible situation of needing to provide lifeguards on beaches the next day. Mr Pender drowned before there were any lifeguards on any beaches.

iii) The RNLI had considerable difficulties sourcing PPE on the open market. Thought may wish to be given to whether it should have priority access to government stock in the event of a future pandemic.

It is recognised that this was an unprecedented situation that was changing rapidly where there were many competing interests. There do appear, however, to be lessons that can be learned from considered review of what has happened. I am not sure whether responsibility to undertake this best lies with you or the on-going public inquiry. I have written to the Secretary to the inquiry additionally and leave you to resolve between yourselves who is best placed to address this.

Beach Safety concerns generally

I want to put what follows in an accurate context.

In 2019, there were RNLI lifeguards on 248 beaches. There were approximately 1600 lifeguards, the vast majority of whom were employed on a seasonal basis. They were on beaches that saw approximately 18M visitors, they provided 200,000 hours of supervised patrols during the

	course of which 30,000 people were assisted and an estimated 154 lives saved. The total cost came in at £21 million, in respect of which the charity received contributions totalling just under £4 million. In 2016, seven men drowned at Camber Sands in East Sussex. My colleague, HM Senior Coroner Mr Craze, wrote a series of PFDs. This led to the publication by the MCA of previously lacking guidance for landowners and local authorities on how to manage beach safety and is to be welcomed. The MCA also commissioned from DWF a report reviewing legal responsibilities for beach safety that was available in January 2019 but not published until November 2020. It identified a confused and conflicting legal landscape where there was no clear legal duty to provide lifeguards and most owners/occupiers were acting out of social conscience than for any other reason. All stakeholders wanted greater clarity to be introduced. That has not happened and there has been no formal government response to the review. Indeed, it appears as though there is no government department that has responsibility for the area. In a letter from the Secretary of State for Transport, Mr Harper, to me I was informed: Neither the MCA, nor the Department for Transport (DfT), has any wider responsibilities for beach safety policy or legislation. This may provide an explanation for why this concern has remained for so long. As long ago as 2006, a local MP observed that it was a 'ridiculous anomaly' that there was more regulation for swimming in a public pool than there was for swimming in the more dangerous environment of the sea, or that there were stricter standards for working on a vessel at sea than there were for members of the public going to the coast. What is apparent, however, is that a stated intention to reduce drownings by half by 2026 is in real danger of being missed. It is for government to decide whether there should be policy in this area and, if so, who should be responsible for it. My duty is simply to bring the concerns to your attention which I hope I have now discharged.
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 March 2024. 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: - The family of Mr Pender; - The family of Mr Klempar; - The family of Mr Mullen; - The RNLI; - The MCA; - Cornwall Council; - The National Trust 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	**[DATE]** **[SIGNED BY CORONER]** **31.1.24**