DAC BEACHCROFT

Our Ref: [redacted]
Your Ref:
22 November 2024

PRIVATE AND CONFIDENTIAL

HM Senior Coroner – Andrew Cox
County Hall
Treyew Road
Truro
Cornwall
Cornwall

BY E-MAIL ONLY [redacted]

Dear HM Senior Coroner,

Our Client	**:**	**Atlantic Reach Ltd**
Matter	**:**	**Inquest into the death of Robin Van Caliskan**
Date of Incident	**:**	**31 July 2023**

We act for Atlantic Reach Ltd ("the Company"), an Interested Person in the inquest into the death of Robin Van Caliskan, which concluded on 18 September 2024.

At the end of the inquest, the Senior Coroner made a report under paragraph 7(1) of Schedule 5 to the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 (the "PFD Report").

In responding to the PFD Report, the Company is required, by Regulation 29(1) of the Coroners (Investigations) Regulations 2013, to –

a) Provide details of any action that has been taken, or which it is proposed will be taken, whether in response to the report or otherwise, and set out a timetable of the action taken or proposed to be taken; or

b) Provide an explanation as to why no action is proposed.

The Company takes this opportunity again to extend its deepest sympathies to Robin's family and friends.

The matters of concern identified in the PFD Report

In the PFD Report, HM Senior Coroner has referred to two matters of concern, namely –

1. *A risk assessment conducted by the company that took account of existing Health & Safety Guidance concluded that it was not reasonably practicable to use lifeguards except on the relatively few occasions when large inflatables were permitted in the pool.*

2. *While there was felt to be compliance with existing minimum legal standards, a Health & Safety Enforcement Officer with Cornwall Council felt this was borderline. She observed that similar sized companies elsewhere did provide a lifeguarding service. She felt lessons had not been learned and said that the company should be doing more.*

Background to the PFD Report

The decision to make the PFD Report

HM Senior Coroner will recall that at the inquest hearing, submissions were made on behalf of the Company to the effect that it would not be appropriate to make a report to the Company. We will not repeat those submissions here, but refer to some aspects of them below.

Undertaking to review

The Company had already undertaken that it would review its risk assessments for the pool and that it would share the findings with the Coroner and the other Interested Persons. The Company had therefore already committed to the review which the PFD Report effectively invites the Company to carry out.

'Borderline' compliance

The Company expressed its concern regarding the making of a report in circumstances where the evidence, including that of the Enforcement Officer for Cornwall Council and the Investigating Police Officer, was that at the time of the incident, the Company complied with the requirements of relevant health and safety legislation and guidance. Although the Enforcement Officer had described compliance at the date of the incident as "*borderline*", that was not accepted by the Company, did not reflect the position at the date of the inquest – by which time further measures had been implemented – and in any event is not a term which is recognised amongst health and safety professionals.

The changes and improvements the Company had made in response to the incident, prior to the date of the inquest, were set out in detail in the statement of Henry Vernon, the owner and Managing Director of the Company.

The Enforcement Officer was aware of the further controls in place, which had been communicated following the incident, as well as in the statement. Her report for the Coroner, dated February 2024, and apparently updated in April 2024, refers, for instance, to the newly implemented CCTV system. Had the Enforcement Officer considered that the updated measures were insufficiently robust, and that they did not reduce the risk so far as was reasonably practicable, it would have been open to her to take enforcement action then. None has been taken.

HSE Guidance HSG 179

The evidence was that the Company had adopted the guidance set out in HSE Guidance HSG 179, *Health and Safety in Swimming Pools*, and had concluded that the provision of lifeguards was not

reasonably practicable. Instead, multiple other robust control measures were in place to reduce the risk to pool users. That is an approach which is explicitly permitted by HSG 179.

It was submitted that in so far as HM Senior Coroner was concerned, if HSG 179 itself was not sufficiently clear or stringent, that was a matter for the HSE, since similar issues would arise in relation to many other pools in similar circumstances.

Lack of evidence in support of comments

Comparison with other pool operators

In the PFD Report, HM Coroner refers to the Enforcement Officer's evidence *"that similar sized companies elsewhere did provide a lifeguarding service."*

No evidence was adduced to support that comment, which was not included in the Enforcement Officer's report. There was no evidence as to the operators concerned, the extent to which the circumstances regarding those pools were similar or not, or the arrangements in place.

Similarly, no evidence was adduced to support the suggestion that the Company has a higher accident rate than other operators. On the contrary, the evidence was that there had been two RIDDOR reportable incidents in the preceding 10 years. No evidence was provided as to the accident rates at other pools.

Lessons had not been learned

The Enforcement Officer's evidence that "*lessons had not been learned*" related to a previous incident, which occurred in October 2020.

First, as was explained in evidence at the inquest, that incident was very different to the tragic incident involving Robin. It involved an adult and occurred early in the morning, outside peak times, when it would not be expected that a lifeguard would be on duty.

Secondly, the Enforcement Officer suggested that a letter had been written to the Company "*at that time"* which recommended constant poolside supervision. That is not the case.

The letter was not mentioned in the Enforcement Officer's report, was not referred to until the second day of the inquest, and was not adduced in evidence. Following the inquest, the Company requested a copy of the letter. When this was provided, the Enforcement Officer disclosed that – contrary to the impression given at the inquest – it had not been sent at the time of the incident in October 2020, but in February 2021. The Company has no record of ever receiving the letter.

The letter noted that the Company had a good history of compliance with Cornwall Council, that access to the poolside and bather loads appeared to be well-controlled, that staff training was up to date, with a good quantity of on-site first aiders, and that there was a good range of rescue equipment, and four alarm points positioned around the poolside.

The letter noted that "*Although constant poolside supervision will always provide the best assurance of users' safety, where the site specific risk assessment has shown that constant poolside supervision is*

not reasonably practicable, robust alternative measures must be implemented to ensure the safety of pool users".

It went on to state that *"Following a comprehensive review including visiting the premises and reviewing Atlantic Reach's policies and procedures, it is concluded that there were no breaches of safety legislation*".

The specific recommendation in the letter was that the Enforcement Officer *"would advise Atlantic Reach to review some of your policies / procedures and that consideration is given to changing your current poolside supervision or observation methods of the pool to prevent a similar reoccurrence*".

The letter therefore suggested a review of measures to prevent the occurrence of a further incident similar to that which had occurred in October 2020, involving an adult, during an off-peak, early morning swim session. The Coroner heard evidence that the Company did review the measures in place following that incident.

The Company therefore does not accept the suggestion that "*lessons had not been learned*" following the incident in October 2020.

Response to matters of concern identified in the PFD Report

The Company confirms that it has reviewed its swimming pool risk assessments since the inquest and in light of the evidence that was heard. It has again had regard to HSG 179 and the requirement to ensure the safety of pool users so far as is reasonably practicable.

It notes the content of paragraph 16 from HSG 179 which states *"…when you see the term 'so far as is reasonably practicable' in this guidance it means balancing the level of risk against the measures needed to control the real risk in terms of money, time or trouble. However, you do not need to take action if it would be grossly disproportionate to the level of risk."*

As was noted at the inquest, swimming is an activity which involves inherent risk that can never be fully eliminated, and, as HM Senior Coroner noted, even where lifeguards are provided, there is no guarantee that future deaths will be prevented.

In undertaking its review, the Company has considered –

The pool supervision regimes implemented by other pool operators:

- The Company is aware that many larger pool operators have lifeguards, whereas some smaller organisations, which are more comparable to the Company, do not.

Whether it can identify peak times or seasons during a year, when the risks – based on the number and characteristics of likely pool users – are higher than at other times:

- The Company concluded that the identification of such times is possible in theory, but no modelling of risk periods can account for situations where factors such as poor weather, for example, increase the number of pool users or affect their characteristics, with little or no notice.

The practicalities of providing lifeguards:

- The Company's experience is that qualified lifeguards are in short supply. They seek medium to long-term contracts (typically 4-6 months or longer). Retention of lifeguards is challenging, due to the ability of larger pool operators to offer more attractive employment, a more comfortable working environment, and better remuneration.

- Adopting lifeguarding during the peak season would inevitably result in periods of pool closure due to recruitment difficulties and other issues such as lifeguard sickness.

Whether it would be reasonably practicable to provide lifeguards over a set period of time (for instance, between 20 March and 1 November each year):

- This would lead to the same issues as above, but with a higher base cost as the 'lifeguard season' would be longer.

The potential risks associated with having a part-time lifeguard service, in which the degree of supervision changes on an hour-by-hour, day-by-day, or week-by-week basis:

- The Company concluded this was an unpalatable approach. For instance, the constant changing position could lead to pool user confusion or complacency as to the supervision provided.

- Communicating the position effectively, through signage and other means, would be difficult.

The financial implications of providing lifeguards:

- It is difficult to quantify accurately the financial impact of providing a lifeguard service, for instance from March to November, but the Company notes that the cost would be very substantial and would necessitate either significant price increases, and/or a reduction in the range and quality of other services offered.

The Company has concluded that it is not reasonably practicable to provide lifeguard supervision at this time. This position will remain under constant review and will be reconsidered –

- During the annual pool risk assessment review; and also

- In the event that the use of the pool or the characteristics of pool users change significantly; or

- When some other event suggests a review is required.

The Company has also reviewed the control measures currently in place. In addition to the controls referred to in Mr Vernon's statement, the Company has now also –

- Made clear on all swimming pool timetables – both online and in the Leisure reception area – that lifeguards are not provided.

- Created a Swim Safe page on their website which provides pool users with key safety information, including –

    - Confirmation that there are no lifeguards;
    - Information regarding the pool safety rules;
    - Clarification of the child-to-adult supervision ratios.

- Updated and implemented a robust training programme for Leisure staff who may be involved in pool rescues or poolside emergency treatment.

- Installed a dedicated swimming pool first aid kit in the Leisure reception area.

Conclusion

The Company wishes to emphasise that it takes the safety of its pool users – and all guests at the site – extremely seriously. The Company would have carried out the review described above even if HM Senior Coroner had decided not to issue the PFD report. The Company appreciates that the management of health and safety is an ongoing duty and confirms that its procedures will be reviewed regularly and developed as necessary to ensure they remain effective and compliant.

Yours faithfully

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For DAC Beachcroft Claims Ltd