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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Managing Director, Atlantic Reach Limited
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 18/9/24, I concluded the inquest into the death of Robin van Caliskan. A jury found the cause of death as 1a) Drowning. A jury recorded a conclusion of Accidental death.
4	**CIRCUMSTANCES OF THE DEATH** On 31/7/23, Robin, who was aged five, came with his family to Atlantic Reach holiday park in Whitecross, near Newquay for a short holiday. Later that afternoon, the family decided to go for a swim in an indoor pool. There were no lifeguards on duty. The main pool was described as busy and was close to the stipulated maximum capacity. As it was the main holiday season, the pool users included a number of children. For a brief period of time, Robin was not under the direct supervision of his parents. He was found face down in the main pool and recovered to the side where resuscitation was attempted. This was unsuccessful and there was recognition of life extinct at 17:55.
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** are as follows. 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.
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. I was told the company will be reviewing its risk assessment in this regard over the coming weeks in light of the evidence that came out at inquest to consider whether there are any further steps that it may be appropriate to take.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 November 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: - [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. 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]** **18/9/24**