ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Anthony John WILLIAMSON, deceased

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr [redacted], Chief Executive, Maritime & Coastguard Agency** **2. Mr [redacted], Chief Executive, Royal National Lifeboat Institution**
1	**CORONER** I am Andrew Cox, Acting Senior Coroner for the coroner area of Cornwall & 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** An inquest was opened on 11 June and has been provisionally listed for hearing on 28 October.
4	**CIRCUMSTANCES OF THE DEATH** On 31 May, it is understood Mr Williamson, an experienced kayaker, departed from Trebarwith Strand in a group of three. At Cambeath Point, approximately 1 mile south west of Crackington Haven, he rolled in heavy swells and came out of his kayak. He was recovered from the sea but could not be resuscitated. A final cause of death following post-mortem is awaited.
5	**CORONER'S CONCERNS** During the course of the investigation, 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. – It will be for a future inquest to determine how this incident occurred. My current cause for concern is to ensure that there is an adequate level of coastguard cover around the Cornish coastline. To what extent, if at all, has the Coronavirus pandemic caused a reduction in the level of coastguard protection in comparison to 2019? If there has been a reduction in the level of cover, how has this been mitigated? Is the amount of cover now at an acceptable level? It is not clear to me whether there were lifeguards on duty at Trebarwith Strand or

	elsewhere in north Cornwall at the time of this incident. My further, current cause for concern is that, where there may be a reduced lifeguard service, how any shortfall may be mitigated by additional coastguard or other emergency service resource. Is there a published plan giving notice to the public on how the situation is being managed?
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 5 October. 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 [family of Mr Williamson.] 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]** **07.08.2020**