REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], **Chairman British Sub Aqua Club.(BSAC),** **AND** [redacted], **Chairman Dulwich Dive Club.**
1	**CORONER** I am Catherine Mason Senior Coroner, for the area of Leicester City and Leicestershire South
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 27th April 2015 I commenced an investigation into the death of Denis William Patrick Cronin. The Inquest concluded on 8th September 2016. The Coroners Conclusion was: Narrative: Denis Cronin attended Stoney Cove on 26th April 2015 as part of a group of diver s from, and under the instruction and guidance of, Dulwich Dive Club with the purpose of practicing skills as part of his Sports Diver Course. Those organising and planning the dives on behalf of Dulwich Dive Club did not carry out a sufficient risk assessment, follow detailed guidance by BSAC or fully instruct Mr Cronin and / or his buddy. As a result, the dive took place in a way it should not have and a foreseeable risk of free flow occurred. Nevertheless, the situation was retrieved and Mr Cronin and his buddy were able to complete their ascent to the surface. However, at the surface Mr Cronin was struggling and unable to release his weight belt and although his buddy was correctly holding on to him Mr Cronin turned and swam away from him. Had he been able to release his belt, remained with his buddy and used the alternative air supply available to him, on a balance of probabilities he would have been rescued and survived. Cause of death: 1a. Drowning
4	**CIRCUMSTANCES OF THE DEATH** Denis Cronin attended Stoney Cove (a diving site run by Stoney Cove Marine Trials Limited) on 26th April 2015 as part of a group of divers from, and under the instruction and guidance of, Dulwich Dive Club with the purpose of practicing skills as part of his Sports Diver Course. Those organising and planning the dives on behalf of Dulwich Dive Club did not carry out a sufficient risk assessment, follow detailed guidance by BSAC or fully instruct Mr Cronin and / or his buddy. As a result, the dive took place in a way it

	should not have and a foreseeable risk of free flow occurred. Nevertheless, the situation was retrieved and Mr Cronin and his buddy were able to complete their ascent to the surface. However, at the surface Mr Cronin was struggling and unable to release his weight belt and although his buddy was correctly holding on to him Mr Cronin turned and swam away from him. Had he been able to release his belt, remained with his buddy and used the alternative air supply available to him, on a balance of probabilities he would have been rescued and survived.
5	**CORONER'S CONCERNS** 1) No training record is kept to evidence when training / practice took place; 2) Training was not in accordance with BSAC Sports Diver training ; 3) The plan for the second dive was for Mr Cronin to inflate the DSMB from a depth of around 17 metres. It took place at 20 metres. The BSAC instructions for Sports Diver are for the exercise to be conducted at 10 metres. 4) A diver without the necessary qualifications and experience was permitted to teach Mr Cronin with no instruction otherwise. 5) No written risk assessments / templates were completed to ensure those responsible for the dive have focused their minds to relevant circumstances; 6) The dive was not properly planned. A Safety and Development Manager employed by BSAC said he would not have done the final dive in the way that it was planned and conducted. 7) Mr Cronin had previously dived to a maximum depth of 16.5yet he was permitted to dive to 20 metres after an 8 month gap since his last open water dive. 8) Signs containing important information and clearly displayed at several sites at the Dive Centre were not read. Evidence was heard that it was believed that there was not a need because it was not the first visit to the Dive Centre and a map of the site had been printed off the internet in advance of the visit. One witness said that if he had seen the signs then it would possibly have made him think twice about doing the DSMB inflation exercise on another day. 9) The belt configuration meant that there was a foreseeable risk that it could not easily be released.
I.	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 Friday 11th November 2016. 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] (Wife) [redacted] (Parents) Leigh Day Solicitors (Representing Family)

	Clyde &Co Claims. (Representing Stoney Cove) [redacted] Prudential Insurance. Friends Life Insurance. 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]** **16th September 2016**