REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Judith Tetlow, Chief Inspector of Diving. Health and Safety Executive**
1	**CORONER** I am Mrs Dianne Hocking, Assistant Coroner, for the coroner area of Leicester City and South Leicestershire
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** On 09 November 2018 I commenced an investigation into the death of Kevin Robert Miles aged 70 years. **The investigation has not yet concluded and the inquest has not yet been heard.**
4	**CIRCUMSTANCES OF THE DEATH** Mr Miles was undertaking a 're-breather' course with an instructor and was diving at Stoney Cove, Stoney Stanton in Leicestershire on the 25th September 2018 when his instructor noticed that something was wrong with Mr Miles. They made an emergency ascent to the surface and attracted the attention of centre staff who immediately pulled Mr Miles out of the water and called the emergency services. Unfortunately, after resuscitation attempts failed, Mr Miles was declared deceased at the scene. Mr Miles was an experienced diver and had been diving since about 1992. Mr Miles had previously been investigated by [redacted] (Consultant Cardiologist) for symptoms of immersion pulmonary oedema due to a dive in 2015 having been cut short when Mr Miles experienced breathing difficulties and the conclusion was that [redacted] told Mr Miles (confirmed in a letter to Mr Miles' GP dated 27/12/2017) that he should not dive again, not only for the sake of his safety but also for the sake of the safety of any rescuer. The cause of death of Mr Miles has been returned by [redacted] (Home Office Registered Forensic Pathologist) as:- 1a) Unascertained
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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. – An Occupational Health Physician, who is also a UK Sport Diving Medical Referee and an HSE Approved Medical Examiner of Divers certified Mr Miles as fit to dive for two years on the 30 January 2018 based on the information given to her by Mr Miles himself in the medical questionnaire and on her physical examination of him. There is currently no requirement to obtain the diver's General Practitioner records (which are often a 'hub'

	of various information regarding treatment by both hospital and/or private clinic) or otherwise personally enquire into treatment or advice given by any other medical practitioner. In my opinion this system is open for misreporting of health problems or, in fact, failing to report them at all. If there had been a requirement to obtain Mr Miles GP records it would have been quite clear that he had been advised that he should not dive again and presumably the certificate would not have been granted. My concerns are that not only may divers be risking their own lives by not disclosing salient health facts (that is at their own risk) but that they are also putting the lives of potential rescuers/dive buddies at risk as well.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and 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 17 April 2019. 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 following Interested Persons 1. [redacted] – partner of the deceased 2. [redacted] – daughter of the deceased 3. [redacted] of Clyde & Co – representatives of [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]** 20/2/19 **[SIGNED BY CORONER]**