REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Managing Director, The Peligoni Club, 49 A Goldhawk Road, Hammersmith, London. W12 8QP
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
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 the 29th and 30th October 2019, evidence was heard touching the death of **Henry Huw Duncan Campbell Byatt. O**n the 6th August 2017, Harry was free-diving in the sea off Zakynthos in Greece when he sadly drowned. **Medical Cause of Death** 1 (a) Drowning in seawater **How, when, where Harry came by his death:** On 6/8/2017 at around midday, Harry went free diving in deep water (around 30 m) off the coast of Zakynthos in Greece. He failed to resurface. After around 20 mins he was rescued and CPR started. This was sadly unsuccessful. He was recognised as life extinct at the local hospital. **Conclusion of the Coroner as to the death:** Accident
4	Extensive evidence was taken in court. In summary: Harry had been freediving for sport using equipment borrowed from a friend during a break from work at the Peligoni Club. A friend accompanied him as a watcher. He was seen to take increasingly deep dives with no difficulty. His friend retreated to the pontoon nearby whilst he performed one more dive. Sadly he did not resurface and the alarm was promptly raised. His body was spotted deep down on the sea-bed floor and rescue attempted by freediving, but this was unsuccessful due to the depth. SCUBA equipment

	was sourced from a local port, and he was rescued and given resuscitation. His rescuer risked his own life to bring him up. The seawater in this area becomes very deep very quickly. Staff regularly swim, snorkel and free dive in this area, albeit to lesser depths that than undertaken by [redacted]. Rescue from greater than 10m depth is very difficult and would require SCUBA equipment. The sea quickly becomes more than 30 m deep, when even rescue by SCBA becomes very dangerous. The resort had a watchtower system in place at the time to monitor craft out on the water, however it could not be established who was on duty in the watchtower at the material time. Swimmers are not regularly observed whilst in the water.
5	**Concerns of the Coroner:** 1. That the Peligoni Club should consider instructing an appropriate expert to assess whether the club should have on site equipment (SCUBA) and staff that would allow them to effect deep-water rescue. 2. That a buoy and line should be recommended for the use by all swimmers, including staff, who swim in an area of the sea more than 10 m deep. 3. That the system for watchtower manning should include a sign/sign out system. 4. That an appropriate watching system for swimmers as well as sea-craft be put in place.
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. 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	**16th December 2019**

Professor Fiona J Wilcox

HM Senior Coroner Inner West London

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Honorary Professor QMUL School of Medicine and Dentistry