H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Chair of the British Diving Safety Group: [redacted], C/O Royal National Lifeboat Institution, West Quay Road, Poole, Dorset, BH15 1HZ, &** **(2) Chair of the United Kingdom Diving Medical Committee: Dr [redacted], Hyperbaric Medicine Unit, St Richard's Hospital, Spitalfield Lane, Chichester, West Sussex PO19 6SE** **(3) Managing Director of the National Diving and Activity Centre, [redacted], Tidenham, Chepstow NP16 7LQ**
1	**CORONER** I am Katy Skerrett, Senior Coroner for Gloucestershire.
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 18th April 2019 I commenced an investigation into the death of Richard Paul Victor Sanders. The investigation concluded at the end of the inquest on the 17th November 2021. The conclusion of the inquest was Accidental Death. The medical cause of death was 1A Immersion pulmonary oedema.
4	**CIRCUMSTANCES OF THE DEATH** Richard Sanders "Richard" was a 52 year old man who was an experienced diver and attended a Technical Diving International (TDI) Trimix Diver course which was being run from the 10th-13th April 2019. On the 11th April 2019, day 2 of the course, during a dive to 45 metres Richard signalled that he was out of air. He had sufficient air remaining. His instructor provided an alternative source to Richard and the pair ascended. During the ascent Richard removed his regulator and attempted to "bolt" to the surface. Richard became unresponsive at a depth of approximately 8 metres. His instructor brought him to the surface and was assisted in lifting Richard out of the water. CPR was commenced by his instructor, other diving staff and ambulance personnel. Richard was pronounced deceased at scene at 17.18 hours.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence 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 **MATTER OF CONCERN** is as follows. – 1. Whether there is sufficient awareness of the risks & affects of immersion pulmonary oedema by those engaged &/ or participating in the activity of diving. 2. Whether sufficient consideration has been given to the requirement for a "fitness to

	dive" medical certificate as a prerequisite to participation in diving activities. 3. Whether more efficient methods and/ techniques of diver removal from the water could be employed at the diving centre.
6	**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 4pm 2nd March 2022. *Recipients (1) British Diving Safety Group, & (2) UK Diving Medical Committee are to respond to the first two matters of concern identified in paragraph 5.* *Recipient (3) NDAC, to respond only on the third matter of concern identified in paragraph 5.* 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 1. [redacted] (address provided separately), 2. [redacted] HM Inspector of Health & Safety, Health and Safety Executive, 1st Floor Cobourg House, 32 Mayflower Street, Plymouth PL1 1QX, 3. [redacted], Kennedys, Trinity, 3rd & 4th Floors, 16 John Dalton Street, Manchester, M2 6HY. 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.
	Dated 5th January 2022 Signature Ms K Skerrett Her Majesty's Senior Coroner for Gloucestershire