**Newcastle upon Tyne Coroners**
**MRS KAREN L DILKS**
**HM SENIOR CORONER**
**Civic Centre, Barras Bridge, Newcastle Upon Tyne, NE1 8QH**
[redacted]

Date: 25 November 2021
[redacted]

**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

**THIS REPORT IS BEING SENT TO: [redacted] T/A Bounce Til I Die [redacted]**

## 1. CORONER

I am **Mrs Karen L Dilks, Senior Coroner for Newcastle and Acting Senior Coroner for North Tyneside Coroners**

## 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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

## 3. INVESTIGATION and INQUEST

On 13 December 2017 I commenced an investigation into the death of Neil James STEWART. The investigation concluded at the end of the inquest on 27 September 2021. The conclusion of the inquest was

Accidental death by drowning.

The medical cause of death was:

1a Drowning

1b

1c

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## 4. CIRCUMSTANCES OF THE DEATH

Neil James Stewart was born on the 13th October 1987. He travelled to Amsterdam in November 2017 with his girlfriend and friends. On 18th November 2017 he boarded a party boat (organised by Bounce Til I Die (BTID)) which was sailing on the Noordzeekanaal waters around Amsterdam. He was witnessed to jump from the boat and enter the canal and sight of him was rapidly lost. His body was recovered from the said canal on the 3rd December 2017. The Nordzeekanal is 13 miles (21 kilometers) long and 550 feet (170 meters) wide and 50 feet (15.5 meters) deep.

## 5. CORONER'S CONCERNS

**6.** 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 **MATTERS OF CONCERN** are as follows -

The following action is required to avoid future deaths:

(1) Create and adopt a written safety policy/protocol in which you clearly document the steps you will put in place to protect your guests, your expectation of them and their conduct and a clear warning of the risks associated with the events they may attend

(2) Create/adopt a written policy/protocol for providing services (entertainment) at a venue that is associated with risks unique/specific to that venue which should include bespoke warnings/guidance to be given to clients who attend.

(3) When providing entertainment services in venue where another provider is responsible for organisation, safety of guests – discuss with the provider the details and clearly document the distinction in those responsibilities and give guidance to guests accordingly

## 7. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you [redacted] and [redacted] have the power to take such action.

## 8. YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 January 2022. 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.

## 9. 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.

25 November 2021

Karen Dilks H M Senior Coroner for Newcastle upon Tyne Coroners