Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]**, Chief Executive** **Health and Safety Executive** **Redgrave Court** **Merton Road** **Bootle** **Merseyside** **L20 7HS**
1	**CORONER** I am Peter Nieto, senior coroner for the coroner area of Derby & Derbyshire
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 28 April 2022 I commenced an investigation into the death of Kellie Jean POOLE aged 39. The investigation concluded at the end of the inquest on 27 September 2023.
4	**CIRCUMSTANCES OF THE DEATH** Kellie died on 25 April 2022 on the river bank of the River Goyt near to Whaley Bridge in Derbyshire. She had collapsed in the river whilst participating in a led session of cold water immersion. On the evidence it is likely that the cold water triggered her heart to go out of rhythm which then led to her sudden cardiac death. On post mortem examination it was identified that Kelly had an abnormal heart, although she had never been diagnosed with or suspected to have a heart condition. It is likely the heart condition prevented recovery from the heart dysrhythmia.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: I emphasise that the matters of concern do not relate specifically to the circumstances of Kellie's death. It appears that there is increasing public interest and participation in cold water immersion. Businesses have been established which offer led cold water immersion sessions and may offer other types of led activities such as breath work often in combination with the cold water immersion. As businesses they charge participants a fee for the sessions.

	It is recognised that some people may experience an adverse physiological reaction to cold water immersion, which has the potential to be life-threatening. Whilst many leisure or health focussed activities may carry risk, where these are provider led the general expectation must be that participants are informed of risks, have an expectation that reasonable safety measures are in place, and that the provider has suitable training and experience. There seems to be very little oversight of these businesses in their provision of cold water immersion covering matters such as pre-session health advice or warnings, public liability insurance, training and experience of the session leader, first aid training and equipment, or written risk assessments. I am not aware of the issuing of specific health and safety guidance. Some sessions take place in water tanks, but sessions are also held in open water such as rivers, lakes, and reservoirs, and therefore at locations that may in themselves pose risk. Session leaders may have undertaken some form of training, but I am not aware that the nature and quality of the training itself is regulated/quality assured. There is no established UK member organisation for providers of cold water immersion, other than for 'wild' and open water swimming which is a distinct activity, and therefore no form of even voluntary self-regulation. On my understanding the current limits of oversight of cold water immersion providers in effect means that these activities have not received guidance from the Health and Safety Executive or other appropriate bodies. My investigation indicated that local authority environmental health departments are unclear whether they should and how they might monitor and oversee these providers.
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, namely by November 29, 2023. 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] (partner) [redacted] (owner of Breatheolution) I have also sent it to [redacted] (Principal Environmental Health Officer Staffordshire Moorlands District Council/High Peak Borough Council) who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest.

	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	**Dated: 04/10/2023**  **Peter Nieto** **Senior coroner for** **Derby & Derbyshire**