REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Channel Swimming Pilot Federation c/o Keystone Law** 2. **[redacted] – Pilot of the "Anastasia"**
1	**CORONER** I am Mr Zafar Siddique, Senior Coroner for the Black Country.
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 https://www.legislation.gov.uk/uksi/2013/1629/part/7
3	**INVESTIGATION and INQUEST** On 27 July 2023, I commenced an investigation into the death of Mr Iain Hughes dob 7 July 1980 who died on the 4 July 2023. The investigation concluded at the end of the inquest on 8 February 2024. The inquest was heard before myself sitting without a Jury and my conclusion at inquest was one of Misadventure. The medical cause of Mr Hughes death was recorded as 1a) Consistent with Drowning
4	**CIRCUMSTANCES OF THE DEATH** 1. Mr Hughes planned to do a channel swim to raise money for several charities. As part of this preparation they were in touch with the Channel swimming and piloting Federation (CSPF) for guidance and to organise a pilot to escort him across the channel. The pilot was, [redacted] and the crew on the "Anastasia" boat. 2. The initial plan was to do the swim on 4-5 June 2023, but this was postponed to 19 June. On the day of the swim they were met by [redacted] and the CSPF observer, [redacted]. They were given an informal briefing about the swim. [redacted] described this briefing as fragmented. She said she didn't recall any discussion of Iain's safety checks, warning signs to look out for and when the swim would be aborted. 3. During the early parts of the swim he made good progress and was on target for a record swim. The family assisted by preparing his feeds every half an hour. His progress and key observations were recorded on a log by [redacted]. 4. Later his pace started to slow down and dropped from 54 strokes per minute to 51. At approximately 11 hours and 35 minutes into the swim he became submerged in the water.

	5. Despite attempts at rescue and further searches by the coastguard he wasn't recovered. 6. The family and the crew then returned to Dover and statements were taken by the Police. 7. Mr Hughes was then subsequently found in Belgium waters in Oostende on the 4 July 2023.
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 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. – 1. During the course of the inquest, I heard evidence from the pilot, [REDACTED]. He confirmed at around thirty minutes before Mr Hughes became submerged, that he was concerned about progress and that it was likely the swim would be aborted. 2. It is not clear how this was communicated to the family and no action was taken to abort the swim. 3. My concern is this this lack of clarity of who and when should make the decision to abort a swim can result in unnecessary delay and increase risk. 4. I am told by the CSPF they have clear guidance and protocols in place and have been provided with several documents to support this. There is always an element of risk by the very nature of the channel crossing challenge. However, given this incident and confusion about when a swim should be aborted you may wish to review the situation further and how this is communicated to all those involved.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 8 May 2024. 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: The family of Mr Iain Hughes. 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 other 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.
9	**6/03/24** **Z Siddique Senior Coroner**