David Place
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **SECRETARY OF STATE FOR CULTURE, MEDIA AND SPORT** **CHIEF EXECUTIVE OF THE HEALTH AND SAFETY EXECUTIVE**
1	**CORONER** I am David Place, His Majesty's Senior Coroner for the City of Sunderland
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 2nd June 2023 I commenced an Investigation into the death of Mr Joel Kennth Ineson, who died at Hetton Lyons Park, Downs Pit Lane, Hetton-le-hole, Houghton-le-Spring on 1st June 2023 aged 55 years. The Investigation concluded at the end of the Inquest on 4th April 2025. I gave a conclusion of 'Accident', and the medical cause of death having been revealed by the post-mortem examination, was confirmed as: - Ia Drowning Ib Diffuse Myocardial Scarring
4	**CIRCUMSTANCES OF THE DEATH** Joel Kenneth Ineson died at Hetton Lyons County Park on 1st June 2023 by drowning, having participated in an open water swimming event and suffering an unexpected cardiac event.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed a matter 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: – Open Water Swimming is becoming a popular way of keeping fit. Mr Ineson was a keen participant in organised open water swimming events with safety at the forefront of his mind with a reasonable expectation that appropriate safety measures would be in place for

	an organised event. He attended such an event on 31st May 2023 which was well attended, and the organisers indicated that this had been a popular event when it had taken place. This event, like many similar events, charged participants a small fee for the session. The matters of concern were not found to be causative of Mr Ineson's death but were such that there is a risk that future deaths could occur unless action is taken. I was concerned that the evidence highlighted uncertainty and confusion with regard to responsibility for aspects of safety measures leading to some participants not receiving a specific safety briefing, a lack of knowledge of the competency/capability of each and every participant and no understanding as to who was in the water and how many people were in the water at any one time. It became clear in evidence that the activity does not require a licence from the Adventure Activities Licensing Authority and can be undertaken and/or organised by anyone without regulation. Some organisations provide guidance on safety when organising such events, but there is no established UK body that provides regulation for this activity. It was confirmed there is no specific health and safety guidance, nor is there a regulatory compliance requirement regarding pre-session safety briefing, risk assessments, signing in and out of the water systems, emergency plans and/or training for organisers. The evidence indicated there is no oversight of these events which, by definition, take place in outdoor locations that may pose a risk. I shall be glad to be told of any learning arising from this death and timescales and results of your review.
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 5th June 2025. 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: - • Family • Sunderland City Council and their Solicitors • Springboard Sunderland Trust and their Solicitors • Organiser of water-based activity and their Solicitors I have also sent it to the following who may find it useful and of interest: • The Royal Society for the Prevention of Accidents

	I am also under a duty to send the Chief Coroner and all interested persons, who in my opinion should receive it, a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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 this 10th day of April 2025 Signature:  HM Senior Coroner for the City of Sunderland