



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: 1. British Sub Aqua Association Telfords Quay, South Pier Road, Ellesmere Port, Cheshire, CH65 4FL 2. Sub Aqua Association Space Solutions Business Centre, Sefton Lane, Maghull, Liverpool, L31 8BX.
1	CORONER I am Penelope SCHOFIELD, Senior Coroner for the coroner area of West Sussex, Brighton and Hove
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 12 July 2024 I commenced an investigation into the death of Dominic Edward Arthur HURLEY aged 57. The investigation concluded at the end of the inquest on 21 October 2025. The conclusion of the inquest was that: On 8 July 2024 Dominic Hurley was undertaking a dive offshore on the HMS BROMPTON. Towards the end of the dive he became unwell and this led to a rapid uncontrolled ascent. On reaching the surface he was recovered to the diving boat but became unconscious shortly thereafter. CPR was commenced. An air ambulance took him to the Royal Sussex County Hospital in Brighton for treatment. Sadly he did not recover and he sadly died later that day.
4	CIRCUMSTANCES OF THE DEATH On 8 July 2024 Dominic Hurley was undertaking a dive offshore on the HMS BROMPTON. Towards the end of the dive he became unwell and this led to a rapid uncontrolled ascent. On reaching the surface he was recovered to the diving boat but became unconscious shortly thereafter. CPR was commenced. An air ambulance took him to the Royal County Sussex Hospital in Brighton for treatment. Sadly he did not recover and he sadly died later that day.
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: (brief summary of matters of concern) In 2018 Mr Hurley suffered shortness of breath and pulmonary oedema during a dive in Malta. This led to him having a heart bypass on his return to the UK. There was significant family history of cardiac related issues. Time passed but in 2021 and 2023 Mr Hurley sort to renew his diving licence. Mr Hurley completed his self declaration questionnaire. At no stage did he declare the events in 2018 in relation to his dive and nor did he discuss this with the Dr assessing him. It is likely that had the Dr been aware of the previous diving incident a different course of action may have taken. There is currently too much reliance placed on the self declaration questionnaire without any further enquiry or access to previous medical history. This leads to a false



	sense of reality and put the diver and others at potential risk of death on further dives.
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 January 12, 2026. 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 Dominic Hurley • [REDACTED] Hyperdive • Health and Safety Executive (Diving division) • Professional Association of Diving Instructors (PADI) 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. They may send a copy of this report to any person who they believe 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: 18/11/2025 [REDACTED] Penelope SCHOFIELD Senior Coroner for West Sussex, Brighton and Hove