



## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	<p><b>REGULATION 28 REPORT TO PREVENT DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>1 Health and Safety Executive</b> <b>2 British Diving Safety Group</b></p>
<b>1</b>	<p><b>CORONER</b></p> <p>I am HEIDI J CONNOR, Senior Coroner for the coroner area of Berkshire</p>
<b>2</b>	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p> <p>It is important to note the case of <u>R (Dr Siddiqui and Dr Paepre-Rohricht) v Assistant Coroner for East London</u>. This case clarifies that the issuing and receipt of a Regulation 28 report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature and engages no civil or criminal right or obligation on the part of the recipient, other than the obligation to respond to the report in writing within 56 days.</p>
<b>3</b>	<p><b>INVESTIGATION and INQUEST</b></p> <p>The family requested me to refer to the deceased as Kevin. I will reflect that in this report. I conducted an inquest into the death of Kevin John Lapwood which concluded on 16<sup>th</sup> of April 2026. I concluded the following:</p> <p>Kevin Lapwood (aged 63) was acting as a volunteer safety diver for London School of Diving, at Wraysbury Dive Centre, on 12<sup>th</sup> of February 2022. He was part of a diving project in which the lead instructor was paid. He had failed an HSE medical [shorthand we used for a certificate issued by an Approved Medical Examiner of Divers, as required under the Diving at Work Regulations 1997] in October 2021, and did not have any medical examination for diving purposes after that point. It is likely that immersion (particularly in very cold water) played a part in causing his death.</p> <p>I reached a conclusion of misadventure.</p>
<b>4</b>	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>On 20<sup>th</sup> of September 2021, Kevin completed a diver medical participant questionnaire. He replied "no" to all questions apart from being over 45 years of age. He saw his GP, Dr S, on 28<sup>th</sup> of September 2021. Dr S ticked the box which said Kevin had suffered with disease of the heart and circulation (e.g. high blood pressure, angina, heart attack, chest pains, or palpitations).</p> <p>On 4 Oct 2021, he saw Doctor F, a doctor with diving experience who was conducting his examination for the purposes of an HSE medical. Kevin failed that test. He had very high blood pressure and was not on medication for it. His BMI was also too high.</p> <p>Kevin advised AF at the London School of diving that he had failed the HSE medical. Mr T, the manager, advised that he should get sign off from his GP. This exchange of messages</p>



took place in October 2021. It appears that Kevin did not have any other medical examination or sign off after that time.

It was arranged that Kevin would act as the safety diver on the second dive at Wraysbury Dive Centre on 12 February 2022. The lead instructor was DK. He was acting in a paid capacity.

Kevin got into difficulty soon after entering the very cold water that day. Despite efficient rescue and resuscitation efforts, he died at Wexham Park Hospital the next day.

I found his cause of death was:

1a Immersion pulmonary oedema

1b Hypertension

2 Coronary artery disease

## 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.

For the avoidance of doubt, each organisation to which this report is addressed is only required to deal with the issues relevant to their own organisation, listed below.

The **MATTERS OF CONCERN** are as follows:  
(brief summary of matters of concern)

### In relation to British Diving Safety Group:

1. I am concerned about the level of training and awareness nationally – specifically of the medical requirements for volunteers involved in projects like Kevin was.
2. I am concerned about the level of training and awareness around the risks of immersion pulmonary oedema ('IPO') for divers with high blood pressure. Whilst the more common risks of hypertension will be better understood (such as heart attack and stroke), awareness of IPO appears to be less well understood.
3. I am concerned about whether there is sufficient guidance regarding what the role of shore support /surface cover entails. Specifically, should that include having eyes on the water?

### In relation to the Health and Safety Executive:

1. Clarity of the approved code of practice ('ACOP') entitled "Recreational diving projects – Diving at Work Regulations 1997", published in 2014, in the following respects:
  - a. The title of the document – does this document adequately reflect that it also covers volunteers? Is there a risk that, on reading the initial heading of the document, it may be felt that it is not relevant to volunteers working in the capacity that Kevin did?
  - b. Would the reference to "associated guidance" on the title page be better with the use of a hyperlink to guidance such as the volunteer diver guidance note?
  - c. The definition of "diver" in the ACOP is "a person at work who dives". The definition of "at work" is (in summary) an employee or a self-employed person. Although the guidance does go on to deal separately with those in a diving role as part of a project, there is some potential ambiguity here.



	<p>For instance, it may be possible to look at the guidance on Regulation 12 which states that no “diver” shall dive in a diving project unless he has an HSE medical. If “diver” is defined as being somebody at work, then there is a risk that the regulations could be interpreted in the way it appears they were here –ie only applying to somebody who is paid.</p> <p>A careful reading of the guidance should make the position clearer, but I believe there is a remaining risk of misinterpretation without very careful analysis of this document.</p> <ol style="list-style-type: none"><li>2. All the titles of the relevant legislation and guidance refer to diving “at work”. It is easily foreseeable that someone looking at this may assume that is not relevant for volunteers used as part of a diving project. I appreciate that naming legislation is not within the gift of the HSE, but it may be something that could be communicated in relation to future legislation, and taken into account in HSE guidance – particularly the titles of any future guidance.</li><li>3. I am concerned that there is currently no requirement for doctors conducting HSE medicals to confirm that they have advised patients who fail the HSE medical, for reasons similar to those in Kevin’s case, of the risks of IPO.</li></ol>
<b>6</b>	<b>ACTION SHOULD BE TAKEN</b> <p>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.</p>
<b>7</b>	<b>YOUR RESPONSE</b> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 25<sup>th</sup> of June 2026. I, the coroner, may extend the period.</p> <p>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.</p>
<b>8</b>	<b>COPIES and PUBLICATION</b> <p>I have sent a copy of my report to the Chief Coroner and to Kevin’s family via their legal representative. I have also sent this report to the following recipients who have an interest in this matter:</p> <ol style="list-style-type: none"><li>1. Legal representative for London School of Diving.</li><li>2. Wraysbury Dive Centre.</li><li>3. Professional Association of Diving Instructors.</li><li>4. Royal Borough of Windsor and Maidenhead Council.</li></ol> <p>I may also send a copy of your response to any person who I believe may find it useful or of interest.</p> <p>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.</p> <p>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.</p>
<b>9</b>	<b>Dated: 30/04/2026</b>



**HEIDI J CONNOR**  
**Senior Coroner for**  
**Berkshire**