REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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THIS REPORT IS BEING SENT TO:

LIFESHIELD MEDICAL SERVICES LTD FALAISE MAIN ROAD GREAT YARMOUTH NR29 3LW

1 CORONER

I am JACQUELINE LAKE, senior coroner, for the coroner area of NORFOLK

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 23 November 2016 I commenced an investigation into the death of JAKUB DAWID MOCZYK, AGE 22 YEARS. The investigation concluded at the end of the inquest on 13 OCTOBER 2017. The conclusion of the inquest was Medical Cause of Death: 1a) Traumatic Brain Injury; and Conclusion: MISADVENTURE.

4 CIRCUMSTANCES OF THE DEATH

Mr Moczyk was taking part in a boxing match at The Atlantis Arena on 19 November 2016. In round 3, he received a blow to the head and fell to the ground. Mr Moczyk was unresponsive and was taken to the James Paget University Hospital. He did not regain consciousness and died from his injuries on 21 November 2016.

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 will 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) Not all boxers were fully checked prior to the fight taking place, including the deceased's opponent (aged 17 years). The medics did not notice he had not been fully examined.
- (2) The medics did not make the referee/promoter aware that not all the boxers had returned to complete their medical examination before the boxing had started.
- (3) During the 2nd round the deceased's opponent gagged/vomited on 2 occasions. The referee stopped the fight and counted to 8 on both occasions. The medics did not examine the boxer and advise as to his fitness to continue fighting, but relied on the referee to make the decision as to whether the fight should continue. It was known by the medics that the referee was not medically qualified. The medics were aware the referee was also the opponent's own trainer. It was said in response to questioning in this respect, that the referee could be expected to know the boxer and whether he was fit to continue fighting. No account was taken that the referee/trainer may prefer the boxer to continue fighting rather than to stop the fight.

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 December 2017. 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:
	and via his solicitor, at Belmores
	Great Yarmouth Borough Council via their solicitor,
	I am also under a duty to send the Chief Coroner a copy of your response.
	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	19 October 2017 Signed: