


## ANNEX A

### REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p>1. [REDACTED] Leeds Martial Arts College, Alexandra Mills, Baker Street, Morley, Leeds, LS27 0QH</p>
1	<p><b>CORONER</b></p> <p>I am Jonathan David Leach, Area Coroner for the Coroner area of West Yorkshire (Eastern)</p>
2	<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>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 11 April 2017 I commenced an Investigation into the death of Scott Marsden, aged 14. The Investigation concluded at the end of the Inquest on 12 February 2019. The conclusion of the Inquest was a narrative which read as follows:-</p> <p>“On 11 March 2017 the deceased received a blow to the chest during a kickboxing bout. As a result, his heart was adversely affected and notwithstanding treatment he died on 12 March 2017 at the General Infirmary, Leeds.”</p> <p>The medical cause of death was :-</p> <p>1a. Commotio cordis</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>The deceased was taking part in a kickboxing bout when he received a blow to the chest which lead to his death.</p>
5	<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows:-</p> <p>(1) That there is no Defibrillator at the Marshalls Arts College.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <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> <p>By arranging for a Defibrillator to be installed at the premises.</p>

7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 26 June 2019. 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>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, [REDACTED] (parents of the deceased) and to [REDACTED] Child Death Overview Panel Manager, Sheffield Safeguarding Children, Floor 3, Howden House, Union Street, Sheffield, S1 2SH.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p><b>1 May 2019</b></p>  <p><b>Jonathan David Leach</b> <b>Area Coroner</b></p>