Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 [redacted]. CEO. England Boxing
2 ……
3 ……

1 CORONER

I am Robert HUNTER, Senior Coroner for the area of Derby and Derbyshire

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 11/11/2020 I commenced an investigation into the death of Edward Lewis BILBEY aged 17. The investigation concluded at the end of the inquest on 23 December 2020. The conclusion of the inquest was:

I a Cardiac arrest

I b Combined effects of an inherited heart condition, myocardial fibrosis and metabolic disturbance caused by intense physical training and rapid weight loss by dehydration.

Narrative Conclusion : Edward Lewis Bilbey, in preparation for a boxing competition, died as a result of an undiagnosed heart condition in combination with a metabolic disturbance resulting from intense physical training and rapid weight loss and dehydration. His death was in part contributed to by a failure to have adequate safeguarding and child protection measures in place to prevent him from doing so.

4 CIRCUMSTANCES OF THE DEATH

Edward Lewis Bilbey died on the 24th March 2017 at Kings Mill Hospital after collapsing in a boxing ring, preceded by a period of intensive training.

5 CORONER'S CONCERNS

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

From the evidence heard at inquest the court was concerned that:

1. England Boxing did not have in place adequate and enforceable child protection and safeguarding measures.
2. England Boxing did not have in place any policy or procedure for checking and enforcing compliance with its safeguarding or child protection procedures.

At Mr Bilbey's club the registered Welfare Officer had left the club three years prior to Mr Bilbey's death. However, his name was at the time registered on 'The Vault' held and maintained by England Boxing. From the evidence heard at inquest there no thing to demonstrate that the name of the Welfare officer and his contact details were displayed prominent in the club. In fact those details were not displayed at all. There was a registered level 2 couch registered on 'The Vault'. However, in

evidence the witness stated under oath that he did not undertake any training or coaching activities at the club.

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 05 May 2021. 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 Parents of Mr Bilbey, The Secretary of State for Digital, Culture, Media and Sport and The Childrens Commissioner for England.

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and to the Local Safeguarding Board (where the deceased was less than 18). I have also sent it to

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who may find it useful or of interest.

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.

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Robert HUNTER
Senior Coroner for
Derby and Derbyshire
Dated: 10 March 2021