	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Health and Safety Executive.**
1	**CORONER** I am Dr Peter Dean, senior coroner for the coroner area of Suffolk
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 the 30th of January 2015, I resumed the inquest into the death of ANTHONY STEPHEN CLEVELAND, aged 46. The conclusion at the end of inquest was that the death was due to Natural Causes, however there were circumstances in respect of this very sad death that gave rise to concern.
4	**CIRCUMSTANCES OF THE DEATH** Mr Andrew Cleveland attended a gym at a fitness facility in Carlton Colville, Lowestoft on the 11th of June 2013 where he collapsed after exercising unsupervised. He was found a short while later by other gym members who summoned assistance. There was evidence that the attempts that were then made to assist him by staff were not adequate, there appeared to be no recognisable primary survey checking for response, airway and breathing, and there was a delay before recognisable cardio-pulmonary resuscitation was commenced. Mr Cleveland was transferred to hospital after an ambulance arrived but sadly passed away some days later on the Intensive Care Unit. The cause of death was found to be 1a Hypoxic injury post-cardiac arrest due to 1b Severe coronary artery stenosis.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence 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. – It is possible and entirely foreseeable that significant medical problems may arise in an environment where people are exercising and may have underlying medical problems that could predispose them to collapse. Given the severity of the underlying coronary artery disease and subsequent cardiac arrest here it is not possible to say in this particular situation whether this tragic outcome could have been avoided with an earlier and more effective response, but the evidence here was that there was not a level of supervision that enabled the problem to be recognised immediately, and neither was there an adequate attempt to resuscitate once it had been established that a person had collapsed. There was also evidence of absence of adequate risk assessment in respect of gym users, a lack of qualified first aiders, and an absence of formalised national guidance on risk assessment in fitness centres and gyms. There was evidence that

	there was HSE guidance on swimming pool operations, but there is not for other facilities and it was felt that this would help the industry greatly, particularly given the proliferation of such gymnasia in recent years, if there was formalised national guidance on risk assessment in fitness centres and gyms.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the HSE have the power to take such action. Given the issues identified here following this very sad death, I would request that consideration is given to the provision by HSE of either formalised national guidance or a mandatory Code of Practice covering gyms and fitness centres, particularly looking at health screening of prospective gym users, adequate supervision of gym users, the presence of properly trained first aiders at all times, and formalised national guidance on risk assessment in fitness centres and gyms.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 9th of November 2015. 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: Mr Cleveland's family Nirvana Fitness Centre, Carlton Colville, Lowestoft Similarly, you are 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.
9	**Dr Peter Dean 14-9-15**