

Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

<p>REGULATION 28 REPORT TO PREVENT DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1 Secretary of State for Digital, Culture, Media and Sport</p> <p>2</p> <p>3</p>
<p>1 CORONER</p> <p>I am Robert HUNTER, Senior Coroner for the area of Derby and Derbyshire</p>
<p>2 CORONER'S LEGAL POWERS</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>3 INVESTIGATION and INQUEST</p> <p>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:</p> <p>I a Cardiac arrest</p> <p>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.</p> <p>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.</p>
<p>4 CIRCUMSTANCES OF THE DEATH</p> <p>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.</p>
<p>5 CORONER'S CONCERNS</p> <p>The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)</p> <p>Boxing England, A National Governing Body did not have in place any systems to monitor and enforce compliance with Child Protection and Safeguarding issues. Given the media coverage of issues with Child Protection and Safeguarding with British Gymnastics and British Athletics I am concerned that this is endemic amongst Sporting National Bodies.</p>
<p>6 ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action, either by primary or secondary legislation.</p>
<p>7 YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report,</p>

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, 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