	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1.Goals Soccer Centres Plc 2. Football Association 5. [redacted] 6. Chief Coroner
1	**CORONER** I am Mr Joseph Hart, Assistant Coroner, for the coroner area of Liverpool and the Wirral
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 21st August 2018 the Coroner commenced an investigation into the death of Jack Riding. The inquest concluded on the 31st October 2018. The conclusion of the Coroner was one of death from natural causes. There had been a number of issues raised in the course of the inquest but Goals Soccer Centres plc had been represented by the local manager Mr Simpkin and before I concluded whether I was under a duty to prepare this report I asked for further information and any representations. I made it clear in open court that I was contemplating such a report and asked that [redacted] convey that message.
4	**CIRCUMSTANCES OF THE DEATH** On August 13th 2018 Jack Riding was playing football when he collapsed. He suffered from a complex heart condition and in the particular circumstances of this case little could be done to assist him. Jack Riding collapsed and became unresponsive as a genetic heart condition had caused his heart to stop whilst playing football on the 13th August 2018. Resuscitation attempts were started almost immediately by bystanders. Paramedics arrived about ten minutes later and Jack was conveyed to University Hospital Aintree where it was ascertained that he had suffered severe hypoxia to his brain. Despite treatment and resuscitation attempts Jack was declared dead at University Hospital Aintree on the 15th August 2018
S5	**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) I heard evidence that there was a significant delay in bringing a defibrillator to the pitch where Jack Riding had collapsed. There was a delay of some minutes before the defibrillator was deployed. I make it clear that this could not be said

	to be a contributing factor in Mr Riding's death. I have received evidence of the systems in place to deploy the defibrillator from Goals Soccer Centres plc. It remains a concern to me that when matches are being played that the defibrillator is kept away from the pitch and the deployment of the equipment is dependent on which members of staff are present. I am concerned that any delay in the deployment of this emergency equipment presents a risk of future death. (2) I heard evidence that there was a significant delay in the ambulance personnel getting to the pitch after arriving at the front gates of the Goals Soccer Centres Plc premises. I saw some CCTV evidence that there was no one in the car park to meet and direct the paramedic crew. I have read the representations, from Goals Soccer Centres Plc, in particular appendix 13 for dealing with the arrival of emergency services, but it remains a concern to me how it is ensured the that policy in place is followed to ensure that in the case of an emergency that valuable moments are not lost by paramedics not being directed appropriately. I have seen Appendix 2 of the response of Goals Soccer Centres Plc which sets out that the personnel at Goals, Liverpool North have been made aware of the new policy but I have seen insufficient evidence of programmes of training to be carried out in the future, or of training drills, or the like. I am concerned that whilst it could not be said on the evidential balance to have contributed to Mr Riding's death, any delay of this kind presents a risk of future death. (3) I have seen a limited risk assessment to consider what should be done in the case of a medical emergency on the pitch. I have seen no clear indication of the extent and subject matter of any first aid training. I have seen evidence that training has taken place. In the absence of any such evidence I am concerned that a lack of training may present a risk of future death. (4) I note that Goals Soccer Centres Plc recognise a need to review the Health and Safety processes. They have instructed an Independent Consultant to undertake a review of Health and Safety processes and procedures but with no clear timescale for this review I am still of the view that I am under a duty to prepare this report.
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 16/1/19. I, the coroner, may extend the period. Given the review commissioned by Goals Soccer Centres Plc I anticipate that a date will be given for the conclusion of that review. I anticipate that this review will provide a response to this report. 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 following Interested Persons Goals Soccer

	Centres Plc, the Football Association and [redacted], father of the deceased. 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	**Mr Joseph Hart** **Assistant Coroner** **Liverpool and the Wirral** 26th November 2018