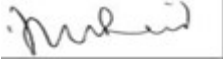


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| | <p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>██████████, Director and sole proprietor, Ultra Events Ltd, Unit 15b Sawley Park, Nottingham Road, Derby, England, DE21 6AS;</p> |
| 1 | <p>CORONER</p> <p>I am David Donald William REID, HM Senior Coroner for Worcestershire.</p> |
| 2 | <p>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>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</p> |
| 3 | <p>INVESTIGATION and INQUEST</p> <p>On 28 April 2022 I commenced an investigation and opened an inquest into the death of Dominic Mark Chapman. The investigation concluded at the end of the inquest on 23 May 2024</p> <p>The conclusion of the inquest was that Mr. Chapman <i>“died as the result of an accident.”</i></p> |
| 4 | <p>CIRCUMSTANCES OF THE DEATH</p> <p>In answer to the questions “when, where and how did Mr. Chapman come by his death?”, I recorded as follows:</p> <p><i>“On 9.4.22 Dominic Chapman sustained a fatal head injury in the course of a charity boxing match organised by Ultra Events Ltd at Tramps nightclub in Worcester. He was taken by ambulance to the Queen Elizabeth Hospital, Birmingham where he succumbed to that injury and died on 11.4.22.”</i></p> |
| 5 | <p><u>CORONER'S CONCERNS</u></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 MATTERS OF CONCERN are as follows. –</p> <p>1) In the course of the inquest I was concerned that criteria set down by Ultra Events Ltd. to match opponents for bouts at the charity white collar boxing event on 9.4.22, specifically relating to the maximum allowable weight difference between boxers, were (a) insufficiently clear, and (b) not always applied by the event organiser. I heard evidence that Ultra Events Ltd. have since changed the wording of those criteria, but was satisfied that, as now drafted, the criteria still lack clarity.</p> <p>For example, ██████████ (director and sole proprietor of Ultra Events Ltd.) told the inquest that the intention behind the reworded criteria was that:</p> <p>(a) any weight difference between boxers of up to 7kg would be acceptable; and</p> |

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| | <p>(b) any weight difference between boxers in excess of 7kg would have to be referred to Ultra Events Ltd.'s head office for approval.</p> <p>However, the criteria contained within the new workbook produced by Ultra Events Ltd. for use by those training and matching up boxers are not as unequivocally clear. For example, the workbook contains the statement: <i>"If a match is over 7kg simply explain it on the fight order"</i>.</p> <p>I am concerned that instructions about weight differences between boxers taking part in charity white collar boxing bouts are important and should be unequivocal, and that coaches and event organisers should be clear about their responsibilities in this respect.</p> <p>2) In his evidence to the inquest, ██████████ (sole director of Ultra Events Midlands Ltd., the franchisee responsible for organising the event on 9.4.22) said that while he left the specifics of the boxers' 8 week training regime to the owner of the gym they used for this purpose <i>"we don't allow sparring until about halfway through training, then body sparring from Week 4, and head contact sparring from Week 5."</i></p> <p>By contrast, the gym owner, ██████████, told the inquest: <i>"For the first week we worked on technique and fitness (cardio work); after 2 weeks, I added a bit of body sparring; after 3-4 weeks we added light sparring sessions with shots to the head."</i></p> <p>Other evidence from a number of the boxers themselves satisfied me that in fact the training provided for the event on 9.4.22 did not follow the pattern outlined by ██████████ or anticipated by ██████████.</p> <p>██████████ told the inquest that Ultra Events Ltd. has now produced Training Session planning, and that a proposed Training Workbook will require their coaches to sign a declaration confirming that they will follow this planning. These measures have not yet been brought into force by Ultra Events Ltd., and I am concerned that unless and until they are brought into force, there is a risk that boxers will not receive the standard of training which Ultra Events Ltd. deems safe and appropriate.</p> <p>It is currently unclear when these measures will be introduced, and how they will be disseminated and enforced so as to ensure that coaches and gyms used by Ultra Events Ltd. for charity white collar boxing events follow them to the letter.</p> <p>3) After hearing the evidence at inquest I was concerned that Ultra Events Ltd.: (a) does not carry out a satisfactory individualised risk assessment tailored to each specific event at each specific venue used by them. I heard evidence that, where a venue has previously been used for a white collar boxing event, Ultra Events Ltd. will assume that nothing has changed since then, and relies on the venue notifying them of any potentially relevant changes; (b) does not carry out its own risk assessment for the provision of medical cover at its white collar boxing events. I heard evidence from ██████████ that Ultra Events Ltd. requires the companies it uses for medical cover to carry their own risk assessments, but does not ask to see or to check those risk assessments. This means that there is no effective oversight to ensure that the medical cover provided for each individual event at each venue is based on a suitable individualised risk assessment.</p> |
| 6 | <p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you, as the director and sole proprietor of Ultra Events Ltd., have the power to take such action.</p> |

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| 7 | <p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 1 August 2024. 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>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following:</p> <ul style="list-style-type: none"> (a) [REDACTED], Mr. Chapman's parents; (b) Tramps Nightclub, Worcester; (c) Worcestershire Regulatory Services. <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>6 June 2024</p> <p></p> <p>David REID HM Senior Coroner for Worcestershire</p> |