

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Sheffield Wednesday Football Club, Hillsborough Stadium, Sheffield S6 1SW.
1	CORONER I am Tanyka Rawden, Senior Coroner for the Coroner area of South Yorkshire (West).
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 7 October 2024 I commenced an investigation into the death of Mark Townsend aged 56. The investigation concluded at the end of the inquest on 10 October 2025. The conclusion of the inquest was that Mark died due to natural causes.
4	CIRCUMSTANCES OF THE DEATH On 28 September 2024 Mark Townsend attended the Hillsborough Stadium in Sheffield to watch a football match between West Bromwich Albion and Sheffield Wednesday. Approximately twenty minutes into the game Mark said he was hot. As the second goal was scored, Mark sat down and fell to his side. Mark went into cardiac arrest and was assisted by an off-duty doctor and an off-duty paramedic before a paramedic from the contracted medical provider arrived. Mark was taken to the Northern General Hospital in Sheffield where he died. The medical cause of death was: 1a. Acute myocardial infarction. 1b. Coronary artery disease. 2. Hypercholesterolaemia.
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: The Court heard evidence and viewed CCTV footage which showed that at the point where a steward became aware medical assistance was required, the nearest member of staff with a radio was at the top of a set of metal stairs, near to the bottom of the stairs leading to the X vomitory. Accepting staff are required to roam to deal with their duties, this position was not in line with those outlined on a map of radio locations produced to the Court.

	The CCTV footage shows the following events: • A West Bromwich Albion supporter spoke to a steward to raise the alarm. The steward initially climbed up the stairs to speak to supporters. • That steward signalled to a second steward to raise the alarm. • The second steward began to descend the stairs. • The first steward then began to descend the stairs. • Stewards one and two conversed with a group of other stewards at the bottom of the stairs leading to the W vomitory. • A steward then moved from the group of stewards the bottom of the stairs leading to the W vomitory and ran towards the group of stewards and steward supervisors at the bottom of the stairs leading to the X vomitory following which the call for medical assistance was made by a supervisor. The Court found that the actions of the stewards in moving to the bottom of the stairs leading to the W vomitory, before running towards the group of stewards and supervisors at the bottom of the stairs leading to the X vomitory, demonstrated that they did not know where to find a member of staff with a radio. The time between the second steward arriving at the group of people at the bottom of the stairs leading to the W vomitory, and the time the steward arrives at the group of stewards and supervisors at the bottom of the stairs leading to the X vomitory, was 20 seconds with the radio call being made 11 seconds later. The Court found this period of time did not cause or contribute to Mark's death, but has concerns that delays caused by stewards not being aware where the nearest radio is could cause delays in summoning medical help in the future, and that may give rise to a risk of future deaths.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe 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 8 Decemebr 2025. 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: • The family of Mark Townsend via their representative. • The Sports Ground Safety Authority. 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	13 October 2025