

## ANNEX A

### REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"><li>1. South Central Ambulance Service</li><li>2. Association of Ambulance Chief Executives</li><li>3. National Health Service England (NHSE)</li><li>4. Department of Health and Social Care (DHSC)</li><li>5. Resuscitation Council UK</li><li>6. St John Ambulance</li><li>7. UK National Screening Committee</li><li>8. The British Society for Genetic Medicine</li><li>9. Sudden Cardiac Arrest UK (SCA UK)</li><li>10. Cardiac Risk in the Young (CRY)</li><li>11. The Football Association</li><li>12. Faculty of Sport and Exercise Medicine UK</li><li>13. UK Sports Institute (formerly the English Institute of Sport)</li></ol>
1	<p><b>CORONER</b></p> <p>I am Valerie Charbit, Assistant Coroner, for the coroner area of West London Coroner's Court</p>
2	<p><b>CORONER'S LEGAL POWERS</b></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>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 17 May 2024 an investigation was commenced into the death of ADAM ANKERS whose date of birth was 19 October 2006. The investigation concluded at the end of the inquest on 9 March 2026. The conclusion of the inquest was Adam Ankers collapsed with a cardiac arrest whilst playing football on 31 January 2024. Agonal breathing and cardiac arrest were not identified by the 999 call handler or those on the pitch. An Automated External Defibrillator (AED) device was brought onto the pitch but not used. Basic Life Support was first delivered by paramedics and Adam suffered hypoxic brain injury. Adam was taken to hospital and died on 4 February 2024 following tests concluding brain stem death. He died due to an inherited heart condition (ARVC) which had not been identified at the time of his death. The medical cause of death was:</p> <p>1a hypoxic brain injury 1b cardiac arrest 1c Arrhythmogenic right ventricular cardiomyopathy (ARVC)</p>

4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <ol style="list-style-type: none"> <li>1. On 31 January 2024, Adam Ankers was playing a Foundation grass roots football game. He had a sudden cardiac arrest due to a previously unknown inherited cardiac condition.</li> <li>2. His agonal breathing at the pitch was not identified and he therefore was not given Basic Life Support and no Automated External Defibrillator (AED) was used.</li> <li>3. His paternal grandmother's cousin had been diagnosed with ARVC in 2018 in Scotland but he had failed to cascade important information contained in a letter from a genetic counsellor to Adam's immediate family.</li> <li>4. Adam's grandmother was made aware of ARVC by her cousin in 2022 and she told Papworth Hospital when she was admitted for an ablation. Although a subsequent referral was made back to Papworth Hospital, in error no appointment was made for her despite the triaging of the referral.</li> <li>5. By the time of Adam's death, Adam, his parents, siblings and grandmother had not had any genetic testing for ARVC or the gene variant that had been identified in Glasgow in 2018.</li> </ol>
5	<p><b><u>CORONER'S CONCERNS</u></b></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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>I heard expert evidence from [REDACTED] and other evidence which indicated</p> <p><b>To:</b></p> <ol style="list-style-type: none"> <li>1. South Central Ambulance Service</li> <li>2. NHSE</li> <li>3. DHSC</li> <li>4. Resuscitation Council UK</li> <li>5. St John Ambulance</li> </ol> <p><b>POINT A: That there is difficulty in lay people (trained or not) including ambulance call handlers in understanding the signs of agonal breathing or cardiac arrest</b></p> <hr/> <p><b>To:</b></p> <ol style="list-style-type: none"> <li>1. The Football Association</li> <li>2. Faculty of Sport and Exercise Medicine UK</li> <li>3. The English Institute of Sport</li> </ol>

**POINT B: That the Football Association's Sudden Cardiac Arrest training is not more widely disseminated or mandatory for all FA Accredited and Affiliated leagues and clubs and all grassroots football coaches and referees.**

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**To:**

- 1. South Central Ambulance Service**
- 2. Association of Ambulance Chief Executives**
- 3. NHSE**
- 4. DHSC**
- 5. The Football Association**
- 6. St John Ambulance Service**

**POINT C: That there is a need for better understanding of the use of defibrillators particularly by lay persons and trained first aid persons**

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**To:**

- 1. NHSE**
- 2. DHSC**
- 3. UK National Screening Committee**
- 4. Resuscitation Council UK**
- 5. Cardiac Risk in the Young (CRY)**

**POINT D: That cardiac screening in those aged 14 and upwards reduces the risk of sudden cardiac death and this is not available to all young people or young football players**

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**To:**

- 1. NHSE (NHS Inherited Cardiac Conditions Clinic)**
- 2. DHSC**
- 3. UK National Screening Committee**
- 4. The British Society for Genetic Medicine**
- 5. Sudden Cardiac Arrest UK (SCA UK)**

**POINT E: That cascade communication of genetic or hereditary diseases is imperfect and does not reach more than half of those in families that need to know about it.**

6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>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.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 June 2026. 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><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons and to the <b>LOCAL SAFEGUARDING BOARD</b>. I have also sent it to the following bodies who may find it useful or of interest:</p> <ol style="list-style-type: none"> <li>1. <b>Genomics England</b></li> <li>2. <b>Joint Royal Colleges Ambulance Liaison Committee</b></li> <li>3. <b>The Royal College of Physicians</b></li> <li>4. <b>The Royal College of Pathologists</b></li> <li>5. <b>The Royal College of Paediatrics and Child Health</b></li> <li>6. <b>The British Heart Foundation</b></li> <li>7. <b>The Premier League Defibrillator Fund</b></li> <li>8. <b>Sport England</b></li> </ol> <p>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.</p> <p>I may also send a copy of your response to any other person who I believe may find it useful or of interest.</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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	<p><b>16.04.2026</b> <span style="float: right;"><b>Valerie Charbit</b></span></p>