SPORT RESOLUTIONS

FACT FINDING INVESTIGATION INTO THE DEATH OF EDWARD BILBEY

11 August 2023

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THE INDEPENDENT EXPERTS

Contents

INTRODUCTION

1. Edward Bilbey ("Edward") was born on the 4th May 1999. He used to attend Somercotes Gym in Derbyshire ("Somercotes") with his mother and brothers. There was a boxing gym there and Edward and his brothers became interested in boxing. Edward had his first fight on 11th May 2013, when he was just fourteen. From everything I have read it is clear that he was extremely dedicated to his sport. In the Autumn of 2016 Edward and his brother Henry attended University College Birmingham ("UCB"), to study for an Advanced Apprenticeship in Sporting Excellence (AASE). This was a two year course that involved academic and practical elements. It was designed for talented boxers.

2. On March 24th 2017, Edward fought for the East Midlands Youth Challenge Welterweight title against Tyler Rivers. He had boxed this opponent on 21st January 2017. He had then boxed another opponent for the same belt on 24th February 2017. Many who watched that second fight considered that Edward was hard done by when he lost that fight. Edward was always a very dedicated boxer. Undoubtedly, he was very motivated for the fight that took place on 24th March 2017.

3. Tragically, Edward collapsed at the end of that fight. He died later that evening.

4. Everything that I have read shows that Edward was a remarkable young man. He was of course still a minor, just 17 years old when he died.

5. I have read the tributes from his friends at college. He was obviously very popular. I have read the statement of his mother, Michelle Bilbey, describing his dedication to boxing, his work ethic, and also his kindness and his closeness to her and his brothers. His brother Henry speaks of his determination to be the best he possibly could. His coaches and tutors all speak of his ability, both academically and practically, and of his good nature and impeccable behaviour.

6. I have also read his training journal. The entries reveal an intelligent, thoughtful, insightful, articulate and organised athlete and student. I extend my condolences to all of his family and friends who must still miss him.

INQUEST AND TERMS OF REFERENCE

7. The inquest into the death of Edward Bilbey took place between 14th and 23rd December 2020. The Coroner concluded that the medical cause of death should be recorded as:

- 1a, cardiac arrest, due to
- 1b, combined effects of an inherited heart condition, myocardial fibrosis, and metabolic disturbance caused by intense physical training and rapid weight loss by dehydration

8. The Coroner returned the following narrative verdict:

> *"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 by 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…*
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> *…Given my findings, and as I intimated yesterday, I have a statutory duty to issue a Regulation 28 report, and I intend to do so in relation to England Boxing. The court has not seen any evidence at this inquest that England Boxing have taken any measures to verify compliance with their registration procedures. This is a significant and serious safeguarding issues with regards to persons under the age of 18."*

9. It is as a result of the Regulation 28 report that was sent to the then CEO of England Boxing, Gethin Jenkins, that I was appointed to carry out this factual review by Sport Resolutions. A copy of my terms of reference is enclosed at Appendix 1.

1A INVESTIGATION INTO THE EVENT and REVIEW OF THE INQUEST

10. I have been provided with all of the material that was made available to the Coroner. This included all of the statements and exhibits produced during the course of the police investigation. That investigation was a thorough one, with statements taken from twenty four witnesses who were either eye-witnesses on the night, involved in Edward's preparation for the fight, or expert witnesses relating to the medical causes of death or the training that Edward had undertaken. Unfortunately, the transcripts of the inquest were not released for use in the review until September 2022. Certain additional material and statements were obtained as a result of considering the transcripts of the inquest. However, given the lapse of time since the event, by late 2022 it was not thought useful or appropriate to obtain further evidence from witnesses who had already made statements to the police, and given evidence to the Coroner, at points in time that were much closer to the events concerned.

TRAINING PERIOD LEADING UP TO THE FIGHT/ OVER-TRAINING

11. By 2017 Edward was enrolled on the AASE course at UCB. This was a full-time course that required him to travel from Derby to Birmingham five days a week. The course required him to be registered with an England Boxing club. That club was the Somercotes Elite Amateur Boxing Club. The club was based in a gym called Shinfield's, in Alfreton, Derbyshire and run by Jay Shinfield. Jay Shinfield is a trainer of professional boxers. His family have been involved in boxing for generations.

12. Edward' last fight before 24th March 2017 was on 24th February 2017. That fight was for the same belt that he fought for on 24th March. He lost the fight on that evening. Michelle Bilbey, Edward's mother, and Henry Bilbey, his brother, both outlined how the fight on 24th March came to take place. The winner of the 24th February fight declined to defend his title against either Edward Bilbey or Tyler Rivers, whom Edward had fought in January. The belt was therefore vacated, and Edward and Tyler Rivers were to fight again for the belt. It would seem therefore that the fight could not have been arranged before early March, giving

Edward relatively little time to train specifically for this fight. Henry Bilbey states that the fight was arranged at short notice.

13. Henry Bilbey, in his statement, states that this was not unusual. Sometimes they would have six weeks notice of a fight, sometimes it was much less. It does not appear to be the case that the short notice of the fight had any impact on the pattern of training Edward undertook for the fight on 24th March.

14. We know a lot of detail about Edward's training in the period between 30th January and 12th March 2017. The students on the AASE course were encouraged to keep a reflective training journal. Edward was one of the few students that did so. His journal for "mesocycle 2" provides a complete picture of the training he did during this period. However, it does unfortunately stop twelve days before the fight on the 24th March. Judging by his approach to the previous fight, these twelve days would have included a period of easing down before the fight.

15. The reflective journal reveals the pattern of Edward's training week. On Mondays he did strength and conditioning training at UCB, and trained at Somercotes in the evening. On Tuesdays there was strength and conditioning training at college, followed by a boxing session at college in the afternoon. In some weeks he either had a further session at Somercotes in the evening or would go for a run. On Wednesdays he would run in the morning, have a boxing session later in the morning at UCB, and would train again at Somercotes in the evening. On Thursdays he would have a single evening session at Somercotes. On Thursday 9th February he reported that he felt sharp because he only had the one training session that day. On Fridays he usually trained both at college and the club. On Saturday mornings he would attend a sparring session with the professional boxers at Somercotes. Sunday was a rest day. However, Edward had a part time job. On Sunday 5th February he reported that he had *"a really tough day at work today doing a lot of manual labour. Right now I feel really tired now that I have finished work, however, I think after having had a break from training, I will hopefully feel better in the morning…"*

16. It is apparent from the journal that Edward was regularly training twice a day and on occasion three times per day. The effect of him having a part time job on Sundays meant

that his rest day was of limited value. The reflective journal was prepared as part of his college course. There is no evidence that he ever showed it to a coach at Somercotes. Ivan Cobb, Sport Lecturer at UCB, was in charge of the practical programme that the boxers carried out at the College. In answer to questions from the Coroner at the inquest, he explained that the training done in the boxing sessions at College would be working on technical skills. He stated that he had challenged Edward about doing manual labour on his rest day and the importance of getting proper rest periods during his training.

17. Mr Cobb did review Edward's journal and enter comments upon it. He did commend Edward for filling in his weight and well-being charts. He also gave encouraging feedback when Edward changed his programme to have a rest day after his fight in February. However, the focus of his comments was on the quality of the reflections rather than making comments on the substance of what Edward was doing as part of his training. This, no doubt, was influenced by the fact that the College was not involved in arranging or training the boxers for their contests. The responsibility for that remained with the boxer's club. Similarly, while the academic part of the course included learning about nutrition, physiology and anatomy, and Mr Cobb states he had given advice to the boxers about weight management and the time required to lose weight for a fight, the responsibility for ensuring that he was managing his weight and losing weight appropriately for a fight remained with the boxer and his club coach.

18. Dr Mark Faghy, Senior Lecturer in Exercise Physiology at the University of Derby, was appointed by the Coroner to consider the training that Edward undertook in the period before March 24th. One of his conclusions was that the number of physical training sessions were excessive in proportion to the rest periods. He highlighted the fact that Edward was on occasion training three times per day and the fact that he was not getting a real rest day because of the manual work involved in his job. He observed that rest days were essential in a training programme because it was during rest periods that adaptation occurred, and the gains were made from the training that had been carried out.

19. At the inquest, Dr Faghy stated that it was difficult to say whether the sessions would have caused physical harm, without knowing what the intensity of the sessions were. He agreed with the Coroner that the evidence generally was that Edward was determined and highly

motivated and therefore likely to push himself in training. Dr Faghy noted that Edward had an acute illness a few weeks before the fight on the 24th March. This occurred between the 3rd and 5th March. Edward did not train at all on those three days. He also reported continuing to feel very tired when training on the 6th March, that his run was harder than usual on the 7th March and that his legs ached on the 8th March. Dr Faghy stated that the effect of training before the body had fully recovered from an illness was that it caused physiological stress to the body globally.

20. Dr Faghy also commented that the acute illness could itself be a sign of continuous overtraining as continuous over training suppresses the immune system. In my view Dr Faghy rightly expressed this to only be a possibility. Many people will suffer illnesses that make them unwell in early March. Edward was travelling five days a week by public transport from Derby to Birmingham and back. He was attending college. He would have been at risk of catching illnesses from others in the normal way.

21. Mrs Bilbey in her evidence before the Coroner stated that Edward commented to her in the lead up to the fight on the 24th March that he was tired and that he would take a break after it. She recalled that she had said to Mr Shinfield that she wanted the fight to be "pulled" and that Henry had subsequently told her that Mr Shinfield had said to Edward that he must stop telling his mother everything or he wouldn't be able to fight for the belt. Henry Bilbey in his evidence remembered that Mr Shinfield had said to Edward *"Stop moaning about it, she's getting on to me".*

22. Henry Bilbey also stated in his evidence that he thought Edward had wanted a rest after his fight in February but that the fight on 24th March was too good an opportunity to turn down. Henry's view was that Edward didn't train as hard for the fight on March 24th because he was tired.

23. Dr Faghy also stated that one consequence of overtraining syndrome can be that the resting heart rate is increased. This means that the range between the resting rate and the maximum rate is narrowed, meaning that the stress on the heart is increased during intense exercise.

24. Mr Cobb, in his supplementary statement, accepted that in hindsight he could see that Edward's training had been too much. He had noticed that Edward was working on his rest days, challenged Edward about it, but this had never been followed up.

25. Dr Faghy was also asked in evidence if there had been a disconnect between the two bodies involved in Edward's training and a lack of communication. He agreed: "*It appears that there were multiple influences on, you know, the training activities that were being undertaken without consideration for the crossover between those. And I would expect that, you know, multiple people have an input onto the development of any athlete, not just the junior athlete, and would have some form of communication".*

26. The Coroner accepted Dr Faghy's evidence that the training that Edward had been doing was excessive. He found that there was a missed opportunity from a child protection standpoint because Mr Cobb's observation that Edward was not resting properly on his day off was not followed up with either Edward's mother or Somercote's gym. Whether or not Edward had developed overtraining syndrome has to remain a matter of uncertainty that is incapable now of proof one way or the other. We cannot know if his resting heart rate had in fact increased or whether the illness he suffered in early March was caused by his immune system being suppressed through over training. However, for the purposes of this review, it is clear that Edward was training excessively without sufficient rest periods in the weeks leading up to his death. He was also showing signs of, and complaining of, being tired. This aspect of what occurred in the weeks before his death was not picked up on and prevented because of the circumstance of there being two different bodies, UCB and Somercotes Elite Boxing Club, involved in his training, and there was no or inadequate communication between the two of them.

SOMERCOTES ELITE BOXING CLUB

27. Michelle and Henry Bilbey, in their statements, described how the boys first came to be involved in boxing. Michelle Bilbey attended boxercise classes at Mr Shinfield's gym and took the boys with her. The boys then progressed to doing boxing itself. Mr Shinfield had

run a gym training professional boxers there for many years. He told the inquest that he had been training professional boxers for thirty five years. He stated that an amateur club nearby had lost its premises and had moved to his gym back in about 2010 or 2012 and that eventually this led to the setting up of Somercotes Elite Amateur Boxing Club. Mr Shinfield stated that the amateur coach was originally David Pearson, and that when he left, Mr Shinfield organised sparring with other amateur clubs so that the amateur coaches from those clubs could supervise the sparring. By the time of the fight on 24th March 2017 he said that Alan Bethell was the coach of the amateurs.

28. Henry Bilbey stated that when he and Edward were first boxing at the club, the amateur coach was a man called Craig Field. Mr Field had been involved with the amateur club that originally moved to the Somercotes gym. He said that Craig left after his fourth fight. He next remembered there being various coaches including a man called Shaun Norman being the coach. However, Mr Norman was from Leicester so hardly attended the training sessions. Henry made no mention of David Pearson in his statement, reflecting, perhaps, how long it had been since Mr Pearson had been involved at the Somercotes gym.

29. Henry stated that training sessions were watched by Mr Shinfield and the amateur boxers would not be left on their own. Henry states that there was a year when Mr Shinfield had to oversee their training because there wasn't an amateur coach. He stated that Jamie Dillingham and Alan Bethell took over the coaching about a fortnight before 24th March 2017. In his evidence at the inquest Henry stated that Jamie Dillingham's involvement was acting as a corner at fights rather than doing the coaching. He said that Mr Bethell hadn't been involved as a coach but had given a bit of advice now and then when he brought his son over. They both acted as Edward's cornermen for the fight on 24th March 2017.

30. At the inquest Henry Bilbey stated that Mr Shinfield was their coach. He would have been the only coach present when they sparred with professionals on a Saturday morning. He stated that it was Mr Shinfield who arranged their fights for them. Mrs Bilbey stated that Mr Shinfield had always been the coach as far as she was concerned after Craig Field left.

31. Alan Bethell made a statement and gave evidence at the inquest. He was a level one coach. He had got involved with boxing because his son aspired to be a professional boxer. By

2017 his son was boxing at Somercotes with a view to becoming a professional boxer coached by Mr Shinfield. He stated that he had moved his coaching registration to Somercotes in February of 2017. He did so simply to be able to assist his son. He stated that he attended on Mondays, Wednesdays and Fridays. He said he mainly went there when the professionals were training. He said that he had no involvement in training Edward before he was asked to assist Mr Dillingham as cornerman about one week before the 24th March. He stated that Mr Shinfield was coaching Edward and that it was him alone. *"He (Mr Shinfield) had sole control over the ring and all sparring".*

32. Jamie Dillingham also made a statement and gave evidence to the inquest. He was a level two coach. He was therefore qualified to supervise sparring sessions, (which a level one coach cannot). He had acted as cornerman for Edward on previous occasions. In his witness statement he stated that he ran his own gym at Clay Cross. He stated that he had no involvement in Edward's training and that he was never a coach at Shinfield's gym, as he had his own gym and boxers. He said there had been occasions when he had taken his boxers to Somercotes to spar with Mr Shinfield's boxers.

33. Henry Bilbey described the evening before the fight took place. He stated that Edward wanted to go on a "block run" with Henry but that Mr Shinfield told him not to and that Edward did bag work instead. After the session Mr Shinfield told them to get weighed. Edward had said, *"let's get weighed at home"*. Henry believes he may have said this because he was worried that Mr Shinfield would pull the fight if he was overweight. They did not weigh themselves at the gym. Edward weighed himself on his own scales when he got home. The events of this evening demonstrate though that it was Mr Shinfield who was fully in control and acting in the role of the boys' coach.

34. At the inquest Mr Shinfield denied that he had been the coach of Edward and Henry Bilbey. He accepted that he had given them advice at times but he distanced himself from having anything to do with the running of the Amateur boxing club at Somercotes. The Coroner found that Mr Shinfield was an unreliable witness. He found that Mr Bethell and Mr Dillingham did not act in any official capacity as coaches at Somercotes. He found that the training and coaching of amateurs, and in particular of Edward and Henry, was undertaken

by Mr Shinfield. These findings are entirely consistent with the weight of the evidence that was collected during the investigation and the inquest.

35. Janet Vitti, who at the time of the inquest was Treasurer of the East Midlands Region for England Boxing, set out in her evidence the safeguarding requirements for any amateur boxing club in March 2017. The registration process required Clubs to be registered on "The Vault", England Boxing's online system for registering clubs, coaches and athletes. A Boxing Club couldn't be approved unless it had a coach. Every coach, at whatever level, had to have undertaken an England Boxing coaching course, a Safeguarding course, and had to have a first aid certificate. They would also have to undergo a DBS check. If any sparring was to take place, there had to be a Level Two coach present. A club could begin with just a Level One coach, but it would be on condition that the coach progressed to level two within a year. Coaches had to re-register every year and do a refresher course every three years. Any child joining the gym would have to complete a medical questionnaire and it would have to be countersigned by a parent. Each club was required to have a welfare officer. The contact details for the welfare officer and the child protection policy had to be displayed prominently at the gym where the club was based. Janet Vitti stated that boxing gyms were inspected when they were first registered but not thereafter.

36. Gordon Valentine, the England Boxing Compliance Manager at the time, provided two statements and a number of documentary exhibits, to the inquest. He also gave evidence. When he checked England Boxing's records for the Somercotes gym after the fight, Michelle Bilbey was registered as Club Secretary, and Alan Bethell was the registered coach. A print out from the Vault dated 30th May 2017 shows Michelle Bilbey as Club Secretary, David Pearson as Head Coach and Justin Wheatley as the Welfare Officer.

37. Michelle Bilbey gave evidence that she had been asked to be the Club Secretary by Mr Shinfield so that it would be easier for Mr Shinfield to retrieve the emails that came from England Boxing. She would be asked "to sign the cards" for the boxers. She said that from 2016 her email address had been replaced by Mr Shinfield's. She described herself as the Club Secretary, "in name only". She had no idea who either Justin Wheatley or David Pearson were. She was not aware of there being any club committee.

38. Mr Shinfield in his evidence stated that David Pearson had been the coach when the amateur club had first been set up in about 2015. Mr Pearson had attended for about 8 months but that his job had changed, and he was unable to attend training thereafter. It was at that point that the amateur club had largely folded and many of the parents had left. The evidence at the inquest established that Mr Pearson had not had any involvement at the Somercotes gym for a considerable period of time before March 2017.

39. Justin Wheatley was spoken to by the police officer who assisted the Coroner prior to the inquest. Mr Wheatley indicated that he had been involved at the Somercotes gym through his son attending for a period of about a year up to 2015. He was aware that his name had been put on a form as Welfare Officer. However, he stated to the police officer that he had not had any involvement with the gym since 2015.

40. The effect of the evidence given to the inquest and accepted by the Coroner was that by 2017 the Somercotes boxing club was being effectively run by Mr Shinfield for a small number of junior amateur boxers, including Edward and Henry Bilbey. At that time Mr Shinfield was not registered with England Boxing in any way. He had not taken any England Boxing coaching qualification. He had not attended a Safeguarding course. He did not have an up to date DBS certificate. When Somercotes amateur boxers attended fights, it appears that the cornerman with a level two qualification, such as Mr Dillingham, would be found as required.

41. At the inquest, no criticism was made by the Coroner of the policies that England Boxing had in place at that time regarding the regulation of Clubs, the requirement for coaches to have certain qualifications, and the requirement for there to be a Welfare Officer who was also suitably trained. The issue was not with the policies themselves but with the steps that were taken, or were not taken, to ensure that they were being complied with. Indeed, in respect of the Club run by Mrs Vitti, that complied with the England Boxing requirements, the Coroner expressed the view that it was a model of how a gym should be run and that it created a safe space for young people to develop their physical, emotional and mental wellbeing.

42. When Mr Gordon Valentine was questioned at the inquest, he described England Boxing's Safeguarding policy as pro-active, in the sense that they carried out a large amount of training for coaches, welfare officers and other officials. He stated that they were reactive in terms of responding to complaints and referrals and taking the necessary disciplinary and safeguarding action.

43. Mr Valentine agreed in evidence with Janet Vitti that a club would have its premises inspected when it first applied to be registered with England Boxing and if satisfactory the club would then be registered on the Vault. He was asked what was done to check that the coaching and welfare roles were being properly carried out thereafter and that the people who were club secretary and welfare officer were not simply "sleeping partners". Mr Valentine stated that one safeguard was that the officials had to re-register each year. In terms of policing clubs, Mr Valentine stated that England Boxing would respond to complaints, and that they did receive complaints from officials, members of other clubs and parents. He said that inspections would be intelligence led rather than random.

44. The Coroner, in his judgment, referred to the evidence of Janet Vitti that there were no further compliance checks regarding the welfare officer or coaches at a club after the initial inspection. In relation to the evidence of Mr Valentine, he said this:

"When asked about what systems are in place to ensure or verify compliance once a club has registered, it was apparent that England Boxing does not have such a system in place. Had there been such a system in place at the time, and Mr SHINFIELD's gym had been inspected to ensure compliance, then England Boxing would have been aware of a non-existent welfare officer, a coach who has not undertaken a safeguarding course, or England Boxing's training course. They would also have been aware that Mr SHINFIELD, at the time of Edward's death and Edward's attendance at the gym, that Mr SHINFIELD did not have a current or valid Disclosure and Barring certificate. Had England Boxing made itself aware of the non-compliance situation, immediate action would have been taken. I would find this a fact that this was a serious missed opportunity to protect Edward and all other young people using that gym. The current absence of such procedures poses not only a historical but a continuing risk to child protection and safeguarding. It is no longer acceptable for governing bodies to rely on trust of individuals to assume compliance....Once a club is registered and the necessary fees are paid, the court has not seen any evidence that England Boxing has measures in place to validate and ensure compliance."

45. It is clear from the above that the issue that concerned the Coroner and led to Edward Bilbey being trained in a club that was almost entirely outwith the England Boxing safeguarding procedures, was not the policies themselves, but the absence of steps being taken to ensure they were complied with after initial registration.

MAKING WEIGHT AND DEHYDRATION

46. Edward fought in the welterweight division (64-69kg), so had to be under 69 kilos when he weighed in for a fight. Henry Bilbey stated in both his statement and his evidence to the Coroner that Edward's normal "walk around" weight was between 72 and 73 kilos. This appears to have been common knowledge among Edward's friends on the course at UCB. One of the tributes to him written in the Reflective Journal specifically refers to Edward having to make weight at 69kg from 72kg. The same tribute speaks of how careful Edward was about what he could eat and how they would "tease" him with food. Mrs Bilbey confirmed that Edward was careful about what he ate and would check food labels for the calorie count when they went shopping together.

47. For his previous fight on 24th February, Edward had just made the weight at 68.9kg. It is notable that on his England Boxing Medical Record card, at his initial medical examination on 29th April 2015 Edward's weight was recorded as 68kg. Edward was just fifteen then so it would be unsurprising if he hadn't grown or filled out somewhat in the following two years. Henry Bilbey explained to the Coroner that a fighter would always want to fight in a category where they were at the top end of the weight bracket. It would ensure they were bigger and stronger than their opponent. Ivan Cobb's evidence to the inquest was that he thought Edward would have had to grow in order to move up a division. The dynamic, that a fighter will want to fight in the lowest weight category possible, is inevitable in any sport where there has to be, for obvious reasons, divisions between competitors based on weight.

48. Henry Bilbey also told the inquest of some of the training practices at the Somercotes gym. His evidence was that the professionals frequently trained, either sparring or running, in bin

bags. He was asked if he and Edward did that. He replied, "*Yeah, it was a method to lose the weight, to make it harder, so wearing the bin bag, it enabled you to do that."* This was not something that only occurred in the run up to the fight on the 24th of March 2017. Michelle Bilbey stated that Edward always went running with a bin bag under his clothing. He told her it was what all boxers did. When he came back to the house and removed the bin-liner, the sweat would drip onto the kitchen floor.

49. In his witness statement, Henry Bilbey described a conversation that he and Edward had had with Craig Field about wearing bin bags, when he had still been involved in their coaching. Mr Field had told them that it was different for amateurs because they had to weigh in on the day, rather than the day before as professionals did. He told them, "It's not good for you, don't wear them. Like, if you don't make the weight you don't make the weight." Henry Bilbey was asked by the Coroner if Mr Shinfield told them to train like that. He answered that Mr Shinfield didn't tell them to, but he didn't stop them either. He said that Mr Shinfield was aware that they were doing it to lose weight.

50. The Coroner, in his judgment, stated that such practices could be described as child abuse. He found that the conversation involving Craig Field was a missed opportunity to refer the practice to the welfare officer as a safeguarding matter.

51. Henry Bilbey's evidence was that two to three weeks before the fight Edward was still 72-73kg. He and Henry obviously spoke about it. Edward appears to have commented to his brother that the weight wasn't coming off like it normally did. Michelle Bilbey also noticed that Edward looked different at this time. In her evidence at the inquest, she stated that she spoke to Edward about how much weight he had lost and that he looked thin. He had responded that "I feel thin, Mum, I really do". She stated that it was this that had led to her speaking to Mr Shinfield about pulling the fight, which in turn had led to him telling Edward to stop moaning to his Mum.

52. In the weeks leading up to the fight on 24th March, Edward's tactics for losing weight clearly became more extreme. Henry told the inquest that because Edward's weight "wasn't shifting", it resulted in Edward wearing more bin bags, going in hot baths and training more. Michelle Bilbey noticed that Edward had started to have these hot baths. Sometimes he

would have three baths a day. She wondered if he had started doing this because he had a girlfriend. She also found that he had tried sleeping with two quilts on the bed. In his statement Henry stated that Edward had seen a documentary that described an MMA fighter losing weight prior to a contest by sleeping in clothing, having hot baths and wrapping themselves in hot towels. The programme showed one fighter losing 24lbs in two days. Edward was emulating these extreme weight losing techniques in the run up to the fight on 24th March.

53. Edward and Henry trained at Somercotes on the night before the fight. Mr Shinfield was present. He told them to weigh themselves at the end of the session. He had not told them to weigh themselves before the session. Edward told him that they would weigh themselves at home. Edward had a set of scales in his room which had been calibrated with the scales at the gym. Mr Shinfield did not insist that they do so at the gym. Nor did he personally supervise them doing so. In his judgment, the Coroner found that this was a safeguarding matter, given Edward's age, and that Mr Shinfield should have insisted on Edward weighing himself in the gym in the presence of Mr Shinfield. Had he done so, it would have become obvious that Edward was significantly overweight and unlikely to make the weight the following evening. Henry Bilbey stated that when they did weigh themselves at home, Edward was 70.7kg, so nearly 4lbs over the weight limit. He had a hot bath that night and slept in a tracksuit and T-shirt and under covers.

54. On the morning of the fight Edward had three eggs on a slice of toast for breakfast. Henry does not think he had anything else to eat before they travelled to the fight in the evening. Edward visited his grandmother during the day. He may have had an apple then. He refused a drink when offered one and was seen rinsing his mouth out rather than drinking.

55. Edward and Henry were dropped off for the weigh in at the Post Mill Centre, South Normanton, where the event was to take place, by Michelle Bilbey and Mr Shinfield, who then had to go and collect other friends, including Mr Dillingham, who was to be Edwards's first cornerman that evening. Henry and Edward had bought chicken wraps and energy drinks to eat after the weigh in. Henry remembers Edward telling him that he was starving. Mr Shinfield stated in his statement that the weigh in was due to take place between 6 and 7pm. Michelle Bilbey stated to the Coroner that they arrived early so that Edward and Henry (who was also fighting that evening) could get weighed in and then have something to eat

and drink to try and rehydrate. The fact that they were arriving deliberately early in order to maximise the time between the weigh in and the fight is itself evidence that there was an awareness that fluid loss and fasting on the day had been used as a weight loss tactic.

56. In fact, the weigh in was delayed. Edward and Henry Bilbey were still waiting to weigh in when Mrs Bilbey and Mr Shinfield returned to the venue with Mr Dillingham. The Medical Officer for the event was Dr Christopher Waas, Senior Accident and Emergency Registrar at Lincoln Hospital. The supervisor for the event was Mr Mark Forman. They were to travel together from Lincoln for the event. Dr Waas was working in Lincoln that day. The arrangement, according to Mr Forman, was that Dr Waas would pick up Mr Forman at 4.30 to 5.00pm. In fact, Dr Waas was unable to pick up Mr Forman and his wife, who was also officiating, until 5.30pm. The cumulative evidence from their statements and evidence at the inquest suggests that they arrived at the Post Mill Centre in South Normanton between 7.00 and 7.15pm. Mr Forman thought that the weigh in had been scheduled to start at 6.30 pm so was delayed by about 45 minutes.

57. The delay in the start of the weigh in will have had an impact on the amount of time that Edward had to have something to eat and to be able to rehydrate. According to several of the witnesses to the inquest, boxers do not like to fight on full stomachs. Edward's fight did not in fact take place until somewhere approaching 9.40 that evening. Edward is likely to have been aware of when in the programme of 13 fights that evening his contest was scheduled to take place. He is likely to have had an idea therefore of what time that was likely to be. It is very possible that he arranged to arrive early, knowing that once he had weighed in, there would be a window of time when he could eat and drink.

58. I have seen that there were regulations in place that dictated how late boxers of different ages were allowed to fight. There is no suggestion that those rules were broken or a material factor on this night. I have not been able to find any rules, in force at the time, that stipulated any minimum time between when the weigh in must take place and the commencement of any bout.

59. Edward weighed in just under the limit of 69kg at 68.9kg. He was medically examined by Dr Waas. He was passed fit to fight. It must be emphasised that to onlookers that evening

he was apparently fit and healthy. Neither of his two cornermen had any concerns before or during the fight. The contest itself was described by those who saw it as a close and hard fought contest. Nothing of concern occurred during the fight. There is no evidence to suggest that the fact that Edward was so dehydrated should have been obvious to the examining doctor or anyone else.

60. The post mortem of Edward included analysis by a forensic toxicologist of various samples. The biochemistry tests in relation to renal function revealed that there was an increased ratio of urea to creatine. This finding was consistent with the history of Edward attempting to reduce his weight by means of fluid depletion. It is a marker of dehydration. The opinion of the pathologist, Dr Hollingbury, was that some of the other findings had been caused by systemic insults, for example metabolic derangement and dehydration, occurring while Edward had been training for boxing matches.

61. Dr Faghy also gave evidence about how dehydration makes the blood thicker, or sludgier, and as a consequence results in physiological stress to a number of body systems. The amount of blood pumped by each heartbeat is reduced, which then results in an increased heart rate to try and compensate.

62. Gordon Valentine gave evidence to the inquest that the dangers of dehydration, and the fact that it should not be used as a method of losing weight before a boxing match, were well recognised by England Boxing. He produced in evidence a PowerPoint presentation prepared by Ken Waddington of Hard and Fast ABC, Barnsley. It is titled “Dehydration/ Rehydration, Weight management for the Boxer”. It sets out the risks of dehydration, stating that severe dehydration can cause severe illness or even death. The presentation points out that to replace 1kg of weight you would need to take in 1.5 litres of water. It states that it would be impossible for a boxer to take in 3 litres of water after losing 2kg of body weight in order to make weight, and then be expected to box. The presentation also points out that only weighing a boxer at the end of a training session gives a false reading. It is stated, in terms, that weight management must be done through calorie expenditure and a good training routine. It must not be done through sweating out. By lowering the calorie intake by 500 calories 1lb can be lost per week. A maximum of 1kg weight loss per week should be the goal. The presentation concludes by stating that under no circumstances should a boxer

be made to sweat off to make weight. “For a schoolboy or junior boxer to be made to lose weight in this way could be classed as child abuse.”

63. This presentation was part of the level one coaching course that would have been undertaken by coaches such as Alan Bethell and Craig Field. The Coroner observed that it was in keeping with such training that Craig Field had given the advice he did to Henry and Edward Bilbey about the use of bin-liners when training to lose weight. The Coroner made no criticism of this training or any of the other elements of the syllabus of the training course given to level one or indeed level two coaches. The issue as far as the Coroner was concerned was that this training had not been adhered to and was very far from what had actually happened in Edward’s case.

64. The evidence before the Coroner and his findings reflected the fact that for a sustained period of time Edward, and his brother Henry, had been able to use wholly inappropriate methods for reducing weight before their contests. It must be stressed that Michelle Bilbey had no knowledge of what should or should not be done and cannot be expected to have realised that what was happening was not appropriate. She understandably assumed that her partner, who had many years within the boxing profession, would not do anything that might be potentially harmful.

65. The Coroner found, on ample evidence, that Mr Shinfield was aware that Edward and Henry were training in bin bags. Answers given by Mr Shinfield to the Coroner suggest that he was comfortable with Edward having to lose 1.7kg in the 24 hours before the fight. This is entirely contrary to the advice given to coaches by England Boxing.

66. In the weeks before the fight on 24th March 2017, Edward found that the weight he had to lose was not coming off as it had for previous fights. It may be that he had grown and filled out and was now simply not able to make the weight of 69kg. He resorted to increasingly extreme methods to lose weight through dehydration. The medical evidence accepted by the Coroner suggests that the repeated process of dehydrating himself when training in the weeks before the 24th of March had caused metabolic disturbances that contributed to his death. Edward was dehydrated when he competed on the 24th of March 2017. The delay in the start of the weigh may have contributed to that dehydration, in that it meant that

Edward had less time to rehydrate before his fight. The Coroner did not criticise policies or the stance of England Boxing towards the issue of dehydration and making weight. What he was concerned about was the failure of the Safeguarding regime that allowed the unacceptable methods resorted to by Edward to happen.

67. There is one further factor that may have affected Edward's dehydration that night. Many of the witnesses spoke of how hot and humid the Post Mill Centre was that night. There is, of course, no precise evidence as to how hot it was. Mr Shinfield, in his evidence, stated that he spoke to both boys to tell them to continue "to dab" water because it was so hot. Edward was described as having sweat pouring off him by the end of the fight. It is clear that it was unusually hot in the Post Mill Centre.

THE ORGANISATION OF THE EVENT AND OFFICIALS PRESENT

68. Joseph Elliott was the organiser for the event at South Normanton on the 24th of March 2017. Although he did not give evidence at the inquest, he has subsequently provided a statement for the purposes of this review. He confirms that he had notified King's Mill Hospital of the fact that the event was taking place. He did so by telephone. He indicates that this procedure is now more normally done by email.

69. The supervisor of the event was Mark Forman. In his evidence to the inquest, he set out how he had been involved in boxing since 1994 when his son had starting boxing. He detailed that he had become a boxing judge and then progressed to taking the necessary courses and exams to be a supervisor. He had done this for about eight years before 2017. He agreed with the Coroner that he had plenty of experience. He said that it is the supervisor's responsibility to check the weights of the boxers, ensure that all the officials are doing their duties and that everybody is safe.

70. The various officials required for an event such as this gave statements and evidence to the Coroner at the inquest. There was no suggestion that any of the officials were missing,

inadequately qualified or that any issues arose concerning their functions that evening. One of the referees, James Morgan, was also qualified to be a medical officer at such events.

71. The Medical Officer for the event was Dr Christopher Waas. He is a Senior Emergency Registrar at Lincoln County Hospital. He had acted as a boxing medical officer since 2009. He has attended over 100 boxing events in this capacity. He was well known to many of the officials present that night. By way of example, Janet Vitti said in her statement that she was familiar with him from previous tournaments and held him in high regard. He had been the medical officer for Edward Bilbey's previous fight against Tyler Rivers in January 2017.

72. In his statements, Dr Waas outlined the equipment that he had with him that night. He had a resus bag, an oxygen cylinder and airwave equipment. In the bag he had Adrenalin, Lignocaine, a blood pressure monitoring machine and cuff, oxygen saturation probe, blood glucose monitor and a manual suction for clearing an airway.

73. At the time of this event, the "Advice for Doctors attending Boxing Shows" stipulated the following:

> *Pre bout*
> *Oxygen and resus gear must be near or next to the ring. NO OXYGEN THEN NO BOUTS…*
> *…Drs who work alone must be fully competent and equipped to maintain an airway and administer oxygen*
> *Discuss extrication, transport and exit for unconscious boxer with paramedics and the supervisor*
> *The supervisor is the main person at a show.*

74. The equipment that Dr Waas states he had with him complies with the advice set out above. In his statement made on the 6th of October 2017, Dr Waas stated that he did not have a defibrillator with him and that he did not know of any doctor who would take such a piece of equipment with them to a boxing event.

75. There was no rule or advice in force in March 2017 that required or suggested that a doctor should have a defibrillator with them at the event.

76. Also present that evening was Edward Frost. He was an Emergency Medical Technician of 12 years experience with the East Midlands Ambulance Service. His role was to deal with any minor injuries that might occur and assist as necessary. Dr Waas was not therefore operating alone that evening.

77. Dr Waas was questioned by the Coroner about the medical examination he carried out at the time of the weigh in. He said he would look at the medical history and check if there were any declared medical conditions such as asthma or diabetes. He would look at the current weight and would do a physical examination if the boxer was dropping a weight division. He would check the pupils, ears and ear drums, the mouth and gum shield and do a cardiovascular examination, listening to the heart and lungs. He would check if there was any rib injury and check the hands for recent injuries. He would ask the boxer how they were feeling and if they had had difficulty making weight. He said there had been nothing remarkable about his examination of Edward.

78. No criticism was made by the Coroner of the pre-bout medical examination by Dr Waas. Edward was passed as fit to box.

RESPONSE TO EDWARD'S COLLAPSE

79. Edward collapsed after the fight, just as the winner was about to be announced. His collapse was sudden. His cornerman had not noticed anything amiss immediately after the fight and he was able to thank the referee and his opponent's corner. Professor Simon Suvarna, the Consultant Cardiac Pathologist, told the inquest that examination of the heart showed that there was an established area of fibrosis around the mid-section of the heart. This myocardial fibrosis caused a dysrhythmia in the heart that caused it to stop. He thought that an inherited cardiomyopathy was the most likely explanation for the fibrosis that he found. Professor Suvarna described how Edward would have felt momentarily

lightheaded and would then have collapsed and passed out. The conclusions of the Coroner were that the additional stress to the heart caused by Edward over training and being dehydrated explain why he collapsed on this particular night.

THE CALLING OF AN AMBULANCE

80. Dr Waas was at ringside and immediately entered the ring. He called for his resus bag and immediately began to attend to Edward. At the inquest he described what happened next. "*He was unresponsive. I took control of his head. I could see he was unconscious at this point. He was having irregular respirations, described as kind of agonal breathing, shallow respiration. At this point I grabbed my oxygen and then became aware that Edward's respirations were slowing down further. I requested that an ambulance was called."*

81. We know, with some accuracy, how long it took for an ambulance to arrive. Donna Brady was one of the Judges for the contest that evening. When Edward collapsed, she was next to the ring timer and she switched it on immediately. She did so in order that the ambulance staff would know how long it was since Edward collapsed when they arrived. In her statement she describes that when the ambulance did finally arrive, they first spoke to Alan Bethell, one of Edward's cornermen, who had been helping Dr Waas in the ring, and then went to assist the doctor. She turned the timer off at that stage. The reading was 27 minutes. Allowing for perhaps 2 minutes for the ambulance to park and the conversation with Mr Bethell, it means there was a period of approximately 25 minutes between Edward collapsing and an ambulance arriving at the venue.

82. The emergency service records produced at the inquest record the ambulance service being called at 22:08:57. The telephone number is recorded as ending 6570. It records there being a duplicate call from a number ending 4866. The details recorded are that Edward collapsed taking part in a boxing fight. The caller states in answer to a question that the doctor does not have a defibrillator. The ambulance is recorded as arriving at 22:17:53. This means that the ambulance crew would have entered the hall, spoken to Mr Bethell and then reached Edward and the doctor by approximately 22:19. If it was at

approximately 22:19 that Donna Brady stopped the ring timer, it means that Edward must have collapsed at approximately 21:52. There is then an apparent delay between 21:52 when Edward collapsed, and 22:08:57 when the ambulance is called. It is a delay of 16-17 minutes.

83. There was a transcript of the emergency call provided to the inquest. The caller immediately asks where the nearest “defib” is to the Post Mill Centre. They state that “he is not breathing…they are resuscitating him now”. The caller does not initially know the name of the road they are on but then provides the detail of Market Street. They ask again about the location of a defibrillator and ask for the code. The operator indicates that there is no defibrillator nearby and that an ambulance is on the way.

84. At the inquest the identity of the person who called the ambulance was never established. Mr Philip Wood, who was the Master of Ceremonies on the night, but who is also a level two qualified coach and supervisor, stated in his witness statement and in his evidence that it was obvious to him immediately that an ambulance needed to be called. He turned to Mark Forman who was still at the side of the ring and asked if an ambulance had been called. He stated that Mr Forman told him that one had been. When Mr Forman was questioned about this, he stated that he didn’t know who had called the ambulance but he believed that two or three people had.

85. Joe Elliott, the event organiser, details in his statement that when he saw Edward collapse, he rushed to the ring and passed the oxygen cylinder into the ring for Dr Waas. He states that Dr Waas shouted to him to make sure that someone called an ambulance. Mr Elliott states that he then went to fetch his phone, and because there was so much noise inside went outside to make the call. Once he got outside, he became aware that a Joe Collins, the father of a friend of Edward’s was already on the phone to the ambulance. It became apparent that Mr Collins couldn’t answer all the questions he was asked and that Mr Elliott took over the call. They then waited outside to make sure that the ambulance arrived at the right place. His impression was that the ambulance took some time to arrive.

86. On the account given by Mr Elliott, it is hard to see how the delay of 16-17 minutes occurred. Although some of his recollection of the call with the ambulance operator corresponds

broadly with the transcript, he makes no mention of discussing the whereabouts of a defibrillator, which was the preoccupation of the caller on the transcript.

87. The contemporaneous records are clear that there was such a delay. Several of the witnesses, with various qualifications and significant experience of dealing with England Boxing events, told the inquest that the responsibility in these circumstances for making sure that such a call was made expeditiously, lay with the supervisor. The "Advice for Doctors", set out above, confirms this. Ultimately the responsibility lay with Mr Forman.

THE OXYGEN CYLINDER

88. Dr Waas told the inquest what he did once he had asked for an ambulance to be called:

"By this time I'm getting my equipment together. We have the oxygen bag valve mask. I applied jaw thrust to open the airway and something to help him breathe and stop the tongue falling on the back of the mouth. And then moved on to checking airway and moved on to checking his pulse, and his pulse was absent. I then instructed the compressions to be started. And I think it was Mr Frost who started the compressions in the ring. He was in cardiac arrest."

89. Alan Bethell was asked by Dr Waas to assist with administering oxygen from the oxygen cylinder. His evidence to the inquest was that the oxygen cylinder was not working and that no oxygen came out when it was turned on. Donna Brady also gave evidence that the mother of Tyler Rivers, Edward's opponent, also tried to get into the ring and help shortly after Edward collapsed. She was saying that she had some kind of medical qualification. She was removed from the ring and was not involved in the attempts to resuscitate Edward. However, she was also heard shouting out, *"The oxygen is not working".* This was heard by others and has caused understandable concern to Edward's family and others after that night.

90. This evidence was put directly to Dr Waas by the Coroner. Dr Waas responded, *" No, the oxygen cylinder was full. It holds 460 litres of compressed oxygen. I make a habit of checking it when I'm ringside to ensure it's functioning. So the cylinder was full and oxygen*

was administered almost immediately…. the reservoir bag of the bag valve mask did fill, so that would suggest there was oxygen flowing through the system." Dr Waas detailed in his evidence that he gets his oxygen from the British Oxygen Company (BOC) and that the cylinder is serviced annually. In practice he stated that BOC replace the cylinder annually. He then checks through his bag before each event starts and checks that oxygen is flowing from the cylinder and the flow valve is working. The cylinder contained 460 litres of oxygen.

91. In respect of the comment made by Tyler Rivers mother, it must, first of all, be noted that she was not actually involved in treating Edward that night. Her comment, *"the oxygen isn't working"* also carries with it the ambiguity that she could have meant that the oxygen was not helping Edward, rather than that the cylinder itself wasn't working. Further, at Edward's funeral, she was spoken to by Donna Brady. She told Donna Brady that she had been drinking that night and probably shouldn't have entered the ring. When Donna Brady asked her about the oxygen, she said that she wasn't really sure.

92. In questioning from Mr Robert Bilbey, Edward's father, Dr Waas also explained that there were two valves on the cylinder, one to turn it on and off and another to control the flow rate. It was put to him that the confusion on the part of Mr Bethell may have arisen from the fact that Mr Bethell was not trained to use the cylinder and may have turned the flow valve initially rather than the on/off valve. Dr Waas agreed with that possibility.

93. There were two other medically qualified people in the ring at that time. Edward Frost was directly involved in carrying out CPR for much of the time before the ambulance arrived. He stated that as far as he was concerned there was no problem with the oxygen. James Morgan was also in the ring. He is qualified to perform the role of medical officer at England Boxing events. He too stated that he was not aware of there being any issue with the oxygen.

94. The Coroner's finding was that oxygen was administered that night. I agree that this finding reflects the weight of the evidence. The Coroner found that there was a delay in administering it. It was not clear on what basis he made this finding. Dr Waas stated that he had to change the type of mask he used because when he first began to administer the oxygen Edward was showing signs of some respiratory activity, but this quickly stopped,

and he had to revert to a different type of mask which allowed oxygen to be pumped into Edward's mouth. The Coroner did not quantify what the delay was or what impact it would have had, if any. Having reviewed the evidence and Dr Waas's explanations for what he did at the time, in the context of dealing with an unexpected medical emergency, I do not consider that this is a criticism of substance.

CLEARING THE AIRWAY

95. The Coroner found as a fact that Edward vomited before the ambulance arrived. The evidence in this regard was conflicting and inconsistent. Mr Frost thought it was when Edward was first turned onto his side and before oxygen was applied and a mask was put onto his face. He did not express any concern that Edward's airways needed to be cleared while he was performing CPR. James Morgan did not notice that Edward had vomited before the ambulance arrived. He too did not make any comment to the effect that Edward's airways needed to be cleared. Alan Bethell stated in the inquest that he had commented to the doctor that Edward's throat was blocked and that he had vomited. He was not clear as to whether this was before or after Edward had been put on his side. He did not mention this at all in the statement he made in 2017.

96. Dr Waas stated that Edward did vomit, but only as the ambulance staff arrived. He said that prior to that the airway was clear and dry. He therefore used the paramedics equipment to clear Edward's airway as it was available.

97. In his evidence Dr Waas outlined that as an emergency registrar he has attended hundreds of cardiac arrests in both children and adults. He held qualifications in Advanced Life Support, Advanced Trauma Life Support and Advanced Paediatric Life Support. The Coroner criticised Dr Waas for not using the suction pump he had in his bag to clear Edward's airway. However, none of the medically qualified practitioners who were present in the ring made any such criticism. Indeed, the evidence of all who were present that night was that Dr Waas remained calm, professional and focussed on treating Edward in the period before the ambulance arrived. The Coroner's criticism also begs the question: if

clearing the airway was necessary and Dr Waas had the relevant piece of equipment in his bag to do it, why did he not do so? The criticism was not put directly to Dr Waas for him to deal with. He did say that the airway was clear so no action was necessary before the ambulance arrived. In my view, the evidence, when looked at closely, does not sustain the criticism made by the Coroner.

FAILURE TO CHECK EDWARD'S BLOOD SUGAR

98. Edward's blood sugar was not checked until the ambulance arrived. At that point it was done by Edward Frost. He did it once the ambulance staff had inserted a cannula into Edward's arm. The reading was very low, 0.5. Edward was then given glucose intravenously. When his blood sugar was tested again five minutes later the reading had risen to 8.2, which is within the normal range.

99. The Coroner made a finding that Dr Waas should have checked the blood sugar level earlier. He put to Dr Waas that one of the things that would be taught on the courses he had attended was *"Don't forget the glucose"*. He asked Dr Waas if he considered checking Mr Bilbey's blood sugar level as he had a glucometer in his bag. Dr Waas responded, *"Not at the time because I was occupied with the immediate resuscitation, compressions, ventilations, which is the priority in a cardiac arrest. When the paramedics arrived I did request them to check it, when I had more skilled help available."* The criticism of the Coroner again begs the question that if the blood sugar level did become a clinical priority, why wouldn't Dr Waas have checked it as he had the necessary equipment available? The answer lies in the fact that even if he had tested the glucose level, Dr Waas was not in a position to treat Edward in respect of this before the ambulance arrived. Dr Waas had glucogel available in his medicine bag. This would have been used to treat a patient who was having a hypoglycaemic attack, but not in the circumstances that applied in this case. It would have to be administered orally. That could not have been done in Edward's case as there would have been a risk of the glucogel compromising his airway and the glucogel would not be effective for a patient whose circulation had collapsed as a result of cardiac arrest. Dr Waas did not have glucose with him that could be administered intravenously.

There is no suggestion that he was expected to have glucose with him or that he should have done. Other factors also have to be borne in mind. A medical emergency was unfolding, Edward was not responding to the efforts being made to resuscitate him, the ambulance took longer to arrive than Dr Waas would have expected, and Dr Waas had limited resources available at the time. My assessment is that if there was a failure to test the blood sugar level, it was not a serious one as Dr Waas could not administer glucose to Edward before the ambulance arrived in any event. There is no suggestion that there was any delay to do so once the ambulance staff did arrive. Given that Edward sadly showed no sign of responding to the efforts to resuscitate him, it was also not something that made any difference to the tragic outcome.

MANAGEMENT OF THE HALLWAY AFTER EDWARD COLLAPSED

100. The Coroner was critical of a failure to manage the scene and clear the Post Mill Centre in the aftermath of Edward collapsing in the ring. Immediately after Edward collapsed, witnesses describe that there was a lot of shouting. As already detailed, the mother of Tyler Rivers attempted to get into the ring. However, she was prevented from doing so. Michelle Bilbey was understandably anxious to be with her son. She was restrained and looked after by Mr Shinfield.

101. Philip Wood, the Master of Ceremonies, in his statement said that he ensured that after the mother of Tyler Rivers had left the ring no one else was allowed to enter it. He was aware that some people outside the ring were becoming angry because they believed that one of those who was assisting Dr Waas was using their phone to take pictures. In fact, they were timing the efforts to perform CPR. At the inquest he said that the security staff initially stopped people from entering the ring. He said that he had to ask people over the microphone to clear a path for the ambulance staff and that the security staff quickly did so when the ambulance did arrive. He said that most of the officials looked stunned immediately after Edward collapsed.

102. James Morgan, the referee, was initially also in the ring. When he eventually left, when CPR had been going on for some time, there were still people left in the room who were shouting. It was the security staff who were taking steps to ensure people left and that the way was clear for ambulance staff to reach the ring when they arrived.

103. Janet Vitti, in her evidence to the Coroner, described how she at one point was comforting Donna Brady, who was having a panic attack. They were in a side room from the main room with the ring in it. She described being approached by Mr Forman, who was clearly shocked and stunned by the whole event. She said he looked like a scared rabbit. He asked if he should cancel the show. She told him that he should and that he should get the room cleared. She said at that point there were still a lot of people in the room including children and it was only then that Mr Forman spoke to security and started to get the room cleared. The Coroner described the failure to clear the scene of children promptly as a child protection issue in itself.

104. Mr Forman was the supervisor that night. In his statement dated 25th March, he is silent about what he did or what occurred in the period after Edward collapsed and before the ambulance arrived. He stated that the supervisor is in charge of the whole boxing show. He was asked by the Coroner what happened when Edward collapsed. After describing how Dr Waas began to treat Edward he stated, *"To be honest, it like shocked me, I was like stunned for a few seconds, and then I realised, "Oh, what's going on?" So I just went round to see, Phil, Phil the MC had already said, "Will please, everybody please sit down and take your seats." And then once the ambulance come I asked to Phil to tell everybody that there'd be no boxing and please could they leave the room. And then once the ambulance come, like Michelle said, everybody started to go into the foyer."*

105. Mr Forman was also asked if there was any protocol in place for an event such as this? *"No. There's no, you don't learn anything like that on your official's course at all. Well we didn't then. Because obviously, I think they had had it before in England Boxing, and I think it was 31 years previous they had it somewhere in the North West, Manchester or …."* He was referring by this to the last time there was a fatality at an amateur boxing match in England.

106. From these answers, it is clear that Mr Forman failed to take control of the situation as he should have done, given that he was ultimately the official in charge of the event. Equally clearly, there was no policy or protocol in place to assist him in knowing how he should do so and the training that he had been given had not equipped him to react appropriately to the situation he was presented with. His failure to be able to deal with the situation must be seen in the context of him having considerable experience as a supervisor by 2017.

1B and 1C RECOMMENDATIONS RELATING TO THE FINDINGS, POTENTIAL DISCIPLINARY MATTERS AND OBSERVATIONS ON THE RULES AND PROCEDURES THAT EXISTED AT THE TIME

POTENTIAL DISCIPLINARY MATTERS

107. The Coroner's findings included significant criticisms of Jason Shinfield. Jason Shinfield is an experienced coach of professional boxers. He is licensed by the British Boxing Board of Control. However, he holds no amateur coaching qualification. Gordon Valentine gave evidence that there is no record of him having ever taken any form of England Boxing qualification. The evidence at the inquest was that he did not have a current DBS certificate in March 2017. There was no evidence of him having undertaken a safeguarding course. There was also no evidence of any First Aid or similar qualification. He should not therefore have been training amateurs who were to fight in England Boxing contests. He should not have been coaching children under the age of eighteen.

108. At the inquest there was evidence that he was still continuing to advertise the amateur club on his website in 2020. When a Police officer went to the gym in 2020, there were children doing exercises albeit not sparring, in the gym at the club.

109. Mr Shinfield should not have been running and acting as the coach for the Somercotes gym in early 2017. Further, the way that he did run the gym involving a number, albeit a relatively limited number, of amateur boxers under the age of eighteen, flouted many of the

safeguards that the England Boxing regulations were designed to ensure the safety and wellbeing of young boxers. There was no level two coach supervising the sparring that took place. There was no welfare officer in reality. Mr Shinfield must have known that the registered welfare officer was a parent who was long gone and could no longer possibly fulfil the role. The child protection policy and the identity of the welfare officer were not displayed within the gym as they should have been. On the evidence, it is clear that Mr Shinfield used his connections with people such as Jamie Dillingham, who were qualified level two coaches and who could therefore act as cornermen when his amateur boxers fought under England Boxing rules, to circumvent the need for Somercotes to have in place a level two coach of its own.

110. Mr Shinfield also allowed some dangerous training practices to take place. He allowed amateur boxers under the age of 18 to spar with older professionals. The Level One coaching manual in use in 2017 specifically states that amateurs must not spar with professionals without the written permission of England Boxing and that Juniors must not spar with Seniors. The evidence at the inquest also established that professional boxers at Mr Shinfield's gym habitually trained while wearing bin bags. The coroner found as a fact, on ample evidence, that Mr Shinfield was aware of Edward and Henry Bilbey employing the same tactics. Mr Shinfield was in a relationship with Michelle Bilbey in March of 2017. He was a frequent visitor to their house. He condoned, if he did not actively encourage, some of the techniques that led to Edward being dehydrated when he fought on the 24th of March 2017.

111. Were Mr Shinfield registered with England Boxing, it is abundantly clear that he should be the subject of disciplinary procedures. But, of course, he is not. Should the time ever come when he applied for any sort of qualification or position within England Boxing, I recommend that this review and the judgment of the Coroner at the inquest should be placed before those charged with deciding whether he should be allowed to register with England Boxing or not.

112. I note that the Coroner referred Mr Shinfield to the Lead Authority Designated Officer for the area where Mr Shinfield's gym is located. I have seen the minutes of the meeting that

took place on the 19th of February 2021. That statutory body will continue to review the position as appropriate.

113. In respect of Mr Shinfield, I recommend that the Chief Executive of England Boxing should consider whether Mr Shinfield should be reported to the British Boxing Board of Control for them to consider if he has breached any of their rules. I also recommend that consideration should be given to referring Mr Shinfield to the Disclosure and Barring Service for them to decide if he should be prevented from working with children and/or vulnerable adults.

114. Mr Mark Forman was the supervisor on the 24th of March 2017. I have already set out above the evidence on which I base my conclusion that he failed to take charge and respond appropriately when Edward collapsed that night. He was clearly shocked by what occurred. However, it was incumbent on him to act with professionalism. He was responsible for ensuring that an ambulance was called and he should have taken control of the process of the venue being cleared in a timely manner for when the ambulance did arrive.

115. It was highlighted on several occasions during the inquest that there was no protocol in place to provide guidance for how to react when an emergency such as this occurred. The closest guidance that appeared to apply at the time was that contained in the “Advice to Doctors”, set out above, that extrication, transport and exit for an unconscious boxer should be discussed between the doctor, the paramedics and the supervisor. Mr Forman stated that any such procedures had not formed part of his training as a supervisor.

116. Given the lack of a procedure that he was required, or had been trained to follow, I do not think that Mr Forman’s failures can be regarded as a disciplinary matter. However, they do raise a safeguarding concern. I recommend that Mr Forman should be referred to the Safeguarding officer to ensure that he is fully aware of the current procedures and policies regarding emergency action plans and to ensure that his training is up to date and has included training on the responsibilities of a supervisor in the event of a medical emergency.

117. Dr Waas had with him the correct equipment that he was required to have under the rules as they existed in 2017. He was clearly qualified to clear an airway unassisted and had the equipment necessary to do so. As already discussed, the Coroner found as a fact, and I agree, that he did have oxygen with him on the night. The Coroner did make certain

criticisms of Dr Waas's response on the night. I have already discussed them and set out my views above. Those criticisms must also be seen in the light of the eye-witness accounts that all describe Dr Waas reacting promptly when Edward collapsed and then treating him calmly and professionally during the period before the ambulance arrived.

118. Dr Waas was a very experienced medical officer at boxing events. There is no suggestion that his training was not up to date. He cannot be shown to have failed to comply with any of the rules that were in place at the time. If there were deficiencies in his performance that night, they related to clinical decisions he made in the circumstances of a medical emergency. In my view an England Boxing disciplinary process is not the forum to examine such matters. If the Coroner had had any concerns as to Dr Waas's fitness to practice, he could have made a referral to the General Medical Council. The Coroner did not do so and I bear in mind that the Coroner himself is a medical practitioner. Accordingly, I do not consider that any sort of disciplinary process should be taken concerning Dr Waas.

119. Jamie Dillingham and Alan Bethell were both registered coaches with England Boxing in March of 2017. They acted as the cornermen for Edward on the 24th of March 2017. For Mr Shinfield to be able to coach amateurs, he needed qualified amateur coaches to be willing to act as cornermen for those amateurs when they had bouts. I have considered whether they could be said to have facilitated Mr Shinfield evading the England Boxing rules and safeguarding regime. For that to be alleged against them, it would have to be demonstrated that they were aware that Mr Shinfield had no amateur qualification himself. Alan Bethell stated in terms that he was not aware of what qualifications Mr Shinfield did or did not have and assumed all was in order at the Somercotes gym. The evidence was that Mr Dillingham spent little, if any time, at the Somercotes gym. In the circumstances I do not consider that there is evidence available to justify any disciplinary action being commenced against either of them.

OBSERVATIONS ON RULES AND PROCEDURES

DEFIBRILLATORS

120. In March of 2017, there was no requirement that there should be a defibrillator at a boxing show such as the one that took place at the Post Mill Centre, South Normanton on 24th March. Dr Waas, an experienced England Boxing medical officer did not have one with him as part of his medical equipment. In his witness statement, he stated that he did not know of any medical officer who would take a defibrillator with him to such an event. The transcript of the 999 call also makes it clear that no one had sought to ascertain where the nearest defibrillator was in advance of the event beginning. Again, there was no requirement to do so.

121. I note that the Coroner made no criticism of this in his judgment at the end of the inquest. This reflects, perhaps, the fact that defibrillators were not as commonly available as they are now. Defibrillators are though, an extremely valuable tool for paramedics and doctors when a patient goes into cardiac arrest. As Professor Suvarna explained to the inquest in his evidence, the chances of survival increase the sooner a patient is treated by means of a defibrillator.

122. Mark Forman gave evidence that very shortly after the 24th of March 2017, there was a meeting involving England Boxing and members from the East Midlands region. Three defibrillators were purchased with a view to them being available for the principal three supervisors active in the region to be able to take with them to boxing shows and contests as necessary.

123. The requirements relating to defibrillators has now been substantially changed by the rules within the England Boxing Rule Book 2022:

> *1.3. Defibrillators*
>
> *1.3.1. As of 1st June 2022, a defibrillator is a mandatory requirement. Member Clubs owe a duty of care to and are responsible for the health and safety of all their individual members whilst on Member Club premises.*

Each Club must have the ability to access a Defibrillator and must know how to use the unit. The Defibrillator must be a maximum distance of five minutes full journey (there and back and to get any necessary access) on foot from the club.
Should the Club not have a defibrillator within the designated distance area, then they must obtain a defibrillator and are responsible for the maintenance of it.
1.3.2. All Boxing Shows should have easy access to a defibrillator near the ring.

124. This new rule is obviously a very welcome development. However, it is important that it is a reality on the ground rather than just a provision within the rule book. My recommendation is that this rule must be accompanied by firstly a robust inspection regime to ensure that clubs and club events are complying with the new rule, and also a programme of training to ensure that those involved within England Boxing are trained to use a defibrillator. If it hasn't already occurred, consideration should be given to making competence in using a defibrillator part of the course for a Level Two coach.

MEDICAL EMERGENCY ACTION PLAN

125. The absence of an emergency protocol or procedure at the time of the event on 24th March 2017 was highlighted repeatedly by the Coroner. It also meant that the supervisor had not been properly trained as to how to prepare for and react to such an event. This was a contributory cause of the failure to call an ambulance quickly and the chaotic scenes that occurred after Edward's collapse. The position had already changed by the time of the inquest in 2020. Gordon Valentine produced the new policy and protocol as an exhibit for the Coroner to consider. The Coroner considered that the new Medical Emergency Action Plan was "robust".

126. The Medical Emergency Action Plan (EAP1) is now contained within Annex A1 of the England Boxing Rule Book 2022. It is lengthy and there is no need for me to set it out in full in this review. It is available via the England Boxing website. In summary, the supervisor is responsible for the EAP1 being implemented. The supervisor must notify relevant hospitals in advance that an event is taking place. The EAP1 provides for the supervisor to appoint someone with knowledge of the venue as the Appointed Individual. The Appointed Individual has the specific responsibility of phoning for an ambulance once the ringside

doctor has indicated one is required and the supervisor has immediately told them to do so. The EAP1 specifies the information the Appointed Individual must be ready to give the Ambulance Service. The EAP1 also sets out the action that must be taken by the Supervisor to keep the ring clear, clear the venue if necessary and to contact next of kin if necessary. The EAP1 also sets out duties for the Timekeeper to record relevant timings that may assist in the treatment of the boxer or review of any event

127. I agree with the Coroner that the EAP1 is a robust and comprehensive document that, if followed, should ensure that adequate preparations have been made for an emergency, and a correct response will be provided if an emergency does occur.

128. England Boxing will need to ensure that there is compliance with the new procedures. The Coroner's concern was that in the absence of active efforts to make sure policies and procedures were complied with, those policies, however good in theory, would remain ineffective in safeguarding the welfare of children involved in boxing. To ensure that this is not the case I recommend that England Boxing review the training materials for all England Boxing officials, and the Supervisor in particular, to ensure that they are properly trained to carry out their particular roles, as set out in the EAP1. Any refresher training should also cover the EAP1.

129. To ensure compliance with the EAP1 I recommend that the Supervisor should have to complete a document setting out who the Appointed Individual is, that they have notified the relevant hospital or hospitals as required and that they have provided copies of the Medical Emergency Response Plan to all the relevant England Boxing Officials at the pre event technical meeting as required within the EAP1. The document should be sent to an appropriate England Boxing official, perhaps the regional Welfare Officer, by email before the event begins. This would allow England Boxing to have a way of monitoring the performance of Supervisors to ensure that the EAP1 is being complied with.

130. Evidence provided to me during this fact-finding review suggests that ambulances are often in attendance for Competition events, but not for "Show" events such as the one that took place on the 24th of March. Edward's approach to his fight for the East Midlands Welterweight Challenge belt shows that contests at Show events may be just as

competitive. If an ambulance is present, the risk of any delay in treatment at the scene or transport to hospital is removed completely. I recommend that England Boxing should review current practice of when an ambulance is present for England Boxing events and whether it is desirable and/or practical for this to be made a mandatory requirement.

THE VAULT

131. In March of 2017, the Vault was a relatively new online system for clubs and individuals to register their membership and qualifications with England Boxing. It was the way that England Boxing kept a record and sought to ensure that registered clubs were complying with the requirements, for example, to have an appropriately qualified coach and a welfare officer. These club officials were required to re-register annually.

132. The evidence at the inquest was that the welfare officer at Somercotes, Justin Wheatley, had not had any involvement at the club for a considerable length of time before March 2017. This meant that there was, in effect no welfare officer, who might have stopped the training in bin bags that occurred, or to whom others may have raised similar concerns. However, Justin Wheatley still appeared as the welfare officer on the Vault in May of 2017. This means that either someone else had re-registered him without his knowledge, or the system had failed to flag up that he had not re-registered as he should have done. In either case this was a weakness of the registration procedure in 2017. I recommend that this aspect of the operation of the Vault should be reviewed. It is essential that officials re-register in person, using some form of secure log in, and that the system alerts England Boxing when re-registration has not occurred.

133. Similarly, the evidence at the inquest was that Alan Bethell was registered as the coach at Somercotes on March 25th 2017. He had apparently moved his registration to Somercotes in February 2017. It is not known who was shown as the coach, if anyone, prior to this date on the Vault. When Gordon Valentine obtained a screenshot of what was shown on the Vault in May of 2017, the coach for Somercotes was shown to be Dave Pearson. Similar issues arise regarding the accuracy of this information and how it was able to be entered onto the Vault. Coaches must register in person and the system must be able to flag up

when a coach has failed to re-register, suggesting that a club may no longer have the necessary active coach.

134. Dave Pearson had not had any involvement at the Somercotes gym for a number of years, and then only briefly. Henry Bilbey did not even recall him coaching there. If his registration in May of 2017 as the coach at the Club was simply a historic entry from the past, the Vault had failed to flag up and alert England Boxing that he had not re-registered annually. If his name had replaced Alan Bethell's between March and May of 2017, it begs the question of who did so. It is highly unlikely to have been Dave Pearson. If the system allowed a third party to register him as the coach that is a major weakness of the Vault system that must be reviewed.

135. Alan Bethell had registered himself at Somercotes. When Gordon Valentine checked the system on the day after Edward's death, he was apparently shown as the club coach. This did not reflect the reality of the situation. Alan Bethell was a level one coach. But the Coroner's finding was that he was not the club coach and was only helping out his own son. I suspect that this is a far from unusual scenario. The Vault does not appear in 2017 to have had the ability to distinguish between a coach who was the club coach and was committed to carrying out the coaching, and someone, typically perhaps a level one coach, who was associated with a club but would not have considered themselves responsible for the coaching there and would not have wished to be the designated club coach. This distinction can be important, as the facts of this case have tragically demonstrated. I recommend that the Vault system of registration is reviewed to ensure that it is possible to understand who is a club coach and who is simply a qualified coach at the Club. The simplest way for this to be done would be for there to be a requirement for someone to be registered as the head coach at the club, who understands that by filling that position they carry the ultimate responsibility for all of the coaching that takes place.

136. I also note that Alan Bethell was only a level one coach. Yet he was the only coach registered at Somercotes in March 2017. By March 2017, the Somercotes amateur club had been in existence for some time. According to the evidence given at the inquest, there was only a period of grace of 1 year after it first formed during which it was acceptable for

a club not to have a level two coach. Again, the Vault system failed to pick up the absence of a level two coach at Somercotes in March of 2017.

137. I am conscious that the England Boxing response to the Coroner's Regulation 28 Notice, speaks of the Vault being in its infancy in 2017 and that the system has expanded and "registrations are actively tracked, ensuring accountability". It may well be the case that the system of registration on the Vault has been further developed so that it would now flag up and detect the sort of anomalies that I have highlighted above. My recommendation is that the system should be reviewed to ensure that these deficiencies have been rectified and that it would prevent clubs from being able to operate without a welfare officer or active and properly qualified coach.

INSPECTIONS OF GYMS

138. In her evidence to the inquest, Janet Vitti explained that the practice was that a club gym would be inspected when it was first opened but would not be inspected thereafter. Gordon Valentine in his evidence stated that further inspections would be intelligence led or in response to a formal complaint. The lack of inspections meant that no one from England Boxing was aware that training was being carried out without a level two coach being present, training was being carried out wearing bin bags, and none of the rules regarding safeguarding policies being visible were adhered to. The absence of ongoing inspection of club gyms was perhaps the most serious concern of the Coroner in respect of there being no adequate system to ensure compliance with the safeguarding regime for young boxers. My recommendation is that England Boxing should review current inspection arrangements to assess how re-inspections can be regularly carried out to ensure safeguarding procedures are being followed.

MAKING WEIGHT

139. Edward was clearly struggling to make the weight of 69 kg for his fight on the 24th of March 2017. He had only made the weight by 0.1kg for his fight a month earlier. Making the weight

had clearly been an issue for him for some time. His friends at college knew it was an issue for him. He had a reputation, both at college and at home, of being someone who was very careful about what he ate. As already discussed, his day to day weight was 72-73kg. This weight must be considered in the context of him being an extremely fit young athlete who is unlikely to have been carrying a lot of spare weight at any point. His mother, Michelle Bilbey, thought that he had become extremely thin before the 24th of March.

140. When he had been weighed for a previous medical in April 2015, Edward had weighed 68kg. He may not have been at his fighting weight then, but there is no reason to suppose he was unfit and carrying excess weight. While it is self-evident that there must be weight categories for junior fighters, from a safeguarding perspective, the real possibility of a young boxer increasing in size as they grow and mature, and therefore struggle to make a weight category that they could compete in previously, creates the risk that they might resort to the sorts of expedients used by Edward. This risk is exacerbated by the existence of the sort of documentaries that Henry Bilbey described being in circulation regarding boxers and other fighters losing weight through dehydration. The challenge for England Boxing is how to manage that risk. As the Coroner set out in his judgment, the safeguarding task is to potentially protect young boxers from themselves in these circumstances.

141. In my view, England Boxing should review their training materials for all coaches and welfare officers to ensure that they are mindful of the potentially dangerous dynamic of young boxers struggling to make weights they could make easily before as they physically develop. A further safeguarding opportunity in this context occurs when boxers under the age of 18 have their annual medical examination. I recommend that the examination should include weighing and measuring a boxer annually, reviewing those figures against the previous year's figures, discussing the issue of making weight with the boxer and the doctor then certifying whether or not in their view it is still appropriate for the boxer to continue to fight in the same weight division as they have done previously.

DEHYDRATION

142. The risks of dehydration to both the health and performance of a boxer are well recognised by England Boxing. They are set out in stark terms in the PowerPoint presentation that was produced as an exhibit by Gordon Valentine at the inquest. This has been part of the training given to level one coaches for years. However, there is clearly a culture within some parts of the boxing community that considers dehydration as a legitimate way of reducing weight. As Edward said to his mother when challenged about running in bin bags, “it’s what boxers do.” The fact that the PowerPoint presentation has to set out what the consequences of dehydration are in the context of losing weight in itself demonstrates that there is a problem to be addressed, exacerbated by the sorts of videos I have already referred to. Janet Vitti, in a further statement she made for this review, indicated that she was aware of another instance of a young boxer being made to train in bin bags.

143. It is therefore imperative that the training and education provided by England Boxing is as strong as possible on this issue. I recommend that England Boxing review its training courses for all level one and two coaches, as well as welfare officers, to ensure that the training materials are as clear as possible about the dangers of dehydration. Sadly, it may be beneficial for Edward’s death to be used as an example of what can happen. This issue must also be given the necessary time and prominence within the syllabus to ensure that delegates understand how important it is.

144. England Boxing should also review their safeguarding and disciplinary policies to ensure that it is explicit that such practices are unacceptable for boxers under the age of 18 and are likely to lead to a coach losing their registration.

145. Inevitably, it will not be easy to police these practises. England Boxing, to a degree, has to be reliant on bad practice being reported to them. However, it is important that the response to a report of bad practice is adequate. England Boxing should review their responses to recent reports and the robustness of their investigations into such reports. Any perception that a blind eye has been turned to any previous complaints is likely to undermine the message sent out by the training and education on this issue.

146. In Olympic boxing the weigh in takes place on the day of the contest, unlike in professional boxing where the weigh in typically takes place the day before. This increases the risk of an amateur boxer fighting when dehydrated. They do not have the same opportunity to rehydrate after the weigh in. On the 24th of March 2017, the weigh in was delayed because the necessary officials were held up while travelling to the venue. On the evidence from the inquest, this does not appear to have been perceived to be any sort of safeguarding issue at the time. The weigh in must have begun at about 7.15pm that evening. With 26 boxers to be weighed and have their medicals, the weigh in procedure can only have finished very shortly before the first bout at 8pm.

147. I have not been able to find any rule that existed at the time that stipulated any minimum period for the weigh in to be completed by before the bouts began at a show event. I am aware that there had to be a window of an hour for the weigh in, with rules as to how much weight could be lost or gained, if the fight was a competition fight.

148. The situation regarding weigh-ins is now governed by section 8 of the England Boxing Rule Book. Rule 8.2.3 stipulates, "*For domestic boxing* (such as the event on 24th March 2017), *the weigh in should be 1 hour prior to boxing commencing".* Had this happened on the 24th of March Edward's fight would have had to start considerably later.

149. My recommendation is that England Boxing should review its training materials to ensure that medical officials, supervisors and child protection officers understand the importance of this rule, and further that supervisors are required to certify that this rule has been complied with through a report provided to the regional welfare officer.

150. A contributory factor to Edward's dehydration may have been the temperature in the Post Mill Centre on the 24th of March. Several witnesses remarked on the heat. Edward was described as being covered in sweat both during and immediately after his fight. I have not been able to find any rule or policy that deals with the temperature in the venue. Other sports, such as tennis, have heat protocols in place where the routine of play is altered or stopped if the temperature is too high. Given that there is a risk that boxers, and in particular young boxers, might compete when dehydrated, I recommend that England Boxing review the scientific evidence relating to what temperatures it becomes dangerous to compete,

with a view to introducing rules requiring one of the officials (the doctor or supervisor would seem obvious candidates) to monitor the temperature at the venue, and to stop the competition if the temperature reaches a level at which it would be dangerous to continue.

ACADEMIC COURSES/ COMMUNICATION

151. One of the issues highlighted by the Coroner during the evidence of Dr Faghy, was the lack of communication that took place between Edward's college and his club trainer in relation to his training schedule. The Corner's conclusion was that this had contributed to Edward overtraining in the period before the 24th of March 2017. Nicola Brady, Executive Director of Academic Quality at UCB provided a statement and gave evidence to the inquest. She detailed how UCB had now developed a Fitness Training Booklet, that was to be used by all students undertaking the equivalent course that Edward was taking. The booklet is designed to record all training whether at College, Club or individually, that the student performs. It would also record what training had been planned in any particular week, with an agreed maximum number of hours, with a view to avoiding over training. The training actually done would need to be signed off on a weekly basis by the College, the Club coach and a parent in respect of any individual training. The purpose of the Fitness Training Booklet is to monitor the training of a student in different locations and ensure that over training does not occur.

152. The Coroner was satisfied that this development was a good solution to the risk of over training by an ambitious young boxer whose training was spread over two different organisations. My recommendation to England Boxing in respect of this aspect of this case is to ensure that this best practice is adopted by all colleges that are running courses that are supported by England Boxing in the way it supports the course at UCB.

153. I finish this review by reiterating my condolences to Edward's family and friends. I hope that the improvements that have already been made to safeguarding practice, and the recommendations I have outlined above, help to ensure that other families do not have to suffer as they have.

Charles Thomas, Guildhall Chambers

11 August 2023