REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The RAC Motorsports Association

CORONER

I am Robert Chapman, Assistant Coroner, for the Coroner Area of Rutland and North Leicestershire

CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

INVESTIGATION and INQUEST

On 9th May 2013 I commenced an investigation into the death of **Christian Murray Cecil Devereux,** aged 50. The investigation concluded at the end of the Inquest on 29th April 2014. The conclusion of the inquest was:

The Cause of death was:

1.a. Head injury consistent with being sustained in a road traffic collision

The Conclusion was:

Accidental death as a result of a motor collision.

CIRCUMSTANCES OF THE DEATH

On the 5th May 2013 Mr Devereux was driving his Mini Cooper S motor car in a race at the Donington circuit in Leicestershire when his car was in a frontal collision with a Ford Mustang. As a result of the collision Mr Devereux suffered head injuries from which he died at the scene.

The evidence of the Consultant Forensic Pathologist was that Mr Devereux had suffered (amongst other injuries):

a) A linear skull fracture across the base of the skull which had almost connected to become circumferential.
b) A fracture of the left transverse process of the lower cervical spine over the course of the left vertebral artery
c) The skull fracture and associated bleeding over the base of the skull will have resulted in sudden disruption of electrical signals from the brain to the rest of the body. This is likely to have resulted in almost instantaneous death.

Mr Devereux was wearing a full racing harness and a helmet, and was sitting in an approved racing seat, which had head height "wings" to reduce sideways head movement.

There was little internal intrusion of damage into the car itself. The damage to the Mini was to the nearside front.

The collision was investigated by the police and your technical Director, [redacted] who also came to the Inquest on the 29th April 2014 to give evidence.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In

my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows:

(1) During the collision between the Mini and the Mustang Mr Devereux would have suffered a major movement of his head in a forwards and backwards motion.

(2) It is likely that his head and neck would have suffered an extension and a turning motion as his car spun

(3) He was wearing a helmet which would have added at least 2 kilo's to the weight of his head

(4) The fracture of the skull and his neck had resulted from this movement of his head during the course of the collision.

(5) He was not wearing a HAN's type device, and had he been wearing one it is likely that it would have prevented or reduced the injury he received.

(6) It was estimated by the witnesses that approximately 50% of drivers in that particular race were wearing HAN's type devices.

(7) The cost of buying a HAN's type device is approximately £200, which is considerably less than the cost of a helmet, and a small amount compared with the cost of entering that specific race.

(8) The advantages of wearing the HAN's type device considerably outweigh the disadvantages.

ACTION SHOULD BE TAKEN

The RAC Motorsports Association is concerned with writing of the regulations under which motor sport in the UK is governed and is in a position to influence the wearing of HAN's type devices.

Consideration should be given to:

1. increasing the numbers and types of races where the wearing of a HAN's type device is mandatory,
2. with a view to achieving in a planned way, complete usage on all races,
3. increasing the publicity given for the device,
4. strongly advising drivers to wear the device,
5. Increasing the awareness of new/young drivers.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 21st July 2014. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

[redacted]

I have also sent it to the following who may find it useful or of interest:
The Leicestershire Constabulary

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

23 May 2014 **[SIGNED BY CORONER]**