REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chairman** **Motor Cross Federation** **The Stables** **Little Baldon Farm** **Little Baldon** **Oxfordshire** **OX44 9PU**
1	**CORONER** I am Michael Singleton, Senior Coroner for the Coroner area of Blackburn, Hyndburn & Ribble Valley.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 10th August 2015 I commenced an investigation into the death of Carl Hughes aged 32 years. The investigation concluded at the end of the Inquest which was concluded on the 4th November 2015. The conclusion of the Inquest was that Carl Hughes had died of an accidental death during a Motor Cross event held at Catterall's Farm.
4	**CIRCUMSTANCES OF THE DEATH** On Sunday 2nd August 2015 Carl Hughes was taking part in a motocross event run by the Newton-le-Willows Motor Cross Club which is affiliated to the Motor Cross Federation. During a novice event he fell from his motorcycle and was then run over by another competitor as a consequence of which he sustained fractures to his back which ultimately proved to be fatal.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving arise to concern. In my opinion there is a risk that further deaths will occur unless action is taken. In the circumstances it is my duty to report to you the **MATTER OF CONCERN** is as follows: - That during the course of the Inquest I heard evidence that Motor Cross events of this nature require competitors to wear mandatory protective equipment of helmet, gloves and boots. It was not however mandatory for competitors to wear body protection. I believe that had Carl Hughes been wearing body protection it would have been unlikely that he would have sustained injuries which would have proved to be fatal.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power as an authorising body to take such action by making body protectors mandatory.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st January 2016. I, the Coroner, may extend this period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following interested person, namely: [redacted] The Chief Coroner I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**06 November 2015** **Signed by:** ..... **H M Senior Coroner for Blackburn, Hyndburn & Ribble Valley**