H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: (addresses provided separately)** **(1) The Cotswold Hunt** **(2) The Council of Hunting Associations and the Director of the Masters of Foxhounds Association**
1	**CORONER** I am Katy Skerrett, Senior Coroner for Gloucestershire.
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 4/4/2016 I commenced an investigation into the death of Bonamie Elena Miriam Armitage. The investigation concluded at the end of the inquest held before a jury on the 11th May 2107. The conclusion of the jury was a short form conclusion of accidental death. The medical cause of death was 1A haemopericardium, 1B impact trauma to the anterior central chest.
4	**CIRCUMSTANCES OF THE DEATH** Bonamie Elena Miriam Armitage "Bonnie" was a 9 year old girl who was an experienced and competent rider. On the 2nd April 2016 the Cotswold Hunt met for the last trail hunt of their season. Bonnie was taking part in the Hunt on her Shetland pony. Bonnie was under the supervision of a family friend, who was looking after five children (including Bonnie) on that day. Bonnie was wearing a body and shoulder protector, and a riding hat. Approximately 50 riders met at Miserden house. Riders set off at around 11am on the pre determined course. During the course of the hunt, the family friend and the younger children were towards/ at the back of the hunt. Bonnie was at the back. Bonnie's pony and a large horse ridden by another rider came into close proximity with each other. As the two horses came close together, the larger horse kicked out. Bonnie was struck in the chest, and died as a result of injuries sustained from the kick to her chest. Paramedics attended, and despite extensive resuscitation efforts Bonnie died as a result of the injuries she had received.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. Whilst it should be noted that none of these factors was causative in this particular case, 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) There is no mandatory requirement that all child participants in a Hunt are required to wear personal protective equipment, (2) There is no mandatory requirement that all child participants in a Hunt are required to demonstrate an established level of competence before participating in a Hunt, (3) There is no mandatory requirement that children are supervised by adult riders when participating in a Hunt, and no ratio of adult supervisors to child riders is stipulated.

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6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 4pm 24th July 2017. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons (1) [redacted] – counsel for the family, 1 Harcourt Buildings, Temple, London EC4Y 9DA (2) [redacted] – Commercial Services manager/Safety Adviser, Stroud District Council. Ebley Mill, Westward Road, Ebley, Stroud, GL5 4UB (3) [redacted] – solicitor for a rider at Hunt, DAC Beachcroft Claims Ltd, Portwall Place, Portwall Lane, Bristol BS1 6NA 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	Dated 25th May 2017 Signature Ms K Skerrett Senior Coroner for Gloucestershire

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