ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: British Cycling, Stuart Street, Manchester, M11 4DQ 1. 2. Anne Adams-King, Chief Executive, Welsh Cycling, Wales National Velodrome, Newport International Sport Village, Newport, South Wales, **NP19 4RB.** Craig Brown, Chief Executive, Scottish Cycling, Sir Chris Hoy Velodrome, Emirates Arena, 1000 London Road, Glasgow, G40 3HY Cycling Time Trials, League of Veteran Racing Cyclists, 5. 6. The League International, CORONER I am David Clark Horsley, Senior Coroner for the Coroner area of Portsmouth and South East Hampshire. CORONER'S LEGAL POWERS 2 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 14th March 2014 I commenced an investigation into the death of Richard Frederick PHILLIPS-SCHOFIELD, aged 33. The investigation concluded at the end of the inquest on 12th February 2018. The medical cause of death was head and chest injuries. The conclusion of the inquest was Richard Frederick PHILLIPS-SCHOFIELD died as a result of an accident. CIRCUMSTANCES OF THE DEATH 4 During the afternoon of 9th March 2014, Richard Frederick PHILLIPS-SCHOFIELD was competing in a cycle race on a track at the Mountbatten Centre. Portsmouth. During the last lap of the race he fell from his cycle and sustained unsurvivable head and chest injuries. He was taken to Queen Alexandra Hospital, Portsmouth, where at 13:30 hours on 11th March 2014, he died as a result of those injuries. The injuries were sustained due to Richard coming into contact at speed with an unyielding object after falling from his cycle. **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. -From the evidence given at the inquest, both by witnesses and a video of the race, the steps taken to halt the race after the accident were ineffectual to prevent numerous

cyclists riding through the aftermath of the accident where a number of competitors, including the deceased, were lying injured. I was told in evidence that there are no formal, effective procedures in the regulations of any of the organisations controlling cycle racing in the United Kingdom for stopping a race in the event of an accident or hazard on the track. It would be left to the organisers on site to stop a race in whatever way they felt appropriate. I believe that the various national cycling organisations should consider introducing formal effective procedures for halting races which would be mandatory for all races organised under their regulations.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisations 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 18th April 2018. 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 Mr PHILLIPS-SCHOFIELDs family and to Portsmouth City Council.

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 **21 February 2018**

David Clark Horsley