	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Incarace** **2. ORCi**
1	**CORONER** I am Mrs Louise Hunt, HM Senior Coroner for **Birmingham and Solihull**
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 26/11/2019 I commenced an investigation into the death of Colin Alan North. The investigation has not yet concluded however following receipt of the TV footage of this incident I was extremely concerned about the safety of Stock Car racing events. I understand further racing events are being staged and I felt it necessary to send the report to prevent future deaths before the conclusion of the inquest.
4	**CIRCUMSTANCES OF THE DEATH** Colin North was attending a Stock Car racing event at Birmingham Wheels venue being run by Incarace on 16/11/19. He attended on behalf of his employer to present trophies after races. Following the conclusion of race 3, Mr North walked onto the track through the vehicle gate and walked along the track towards the presentation area which was in the middle of the track. At the time all the race vehicles were still on the track – some doing "doughnuts" and various recovery vehicles were entering the track to remove broken down or damaged vehicle. Two of the recovery vehicles were large tractors. The track has many pedestrians walking round whilst all these vehicles are moving onto the track and there is no control of pedestrians on the track and no pedestrian walk route. As Mr North walks around the track he moves past a recovery vehicle parked on his right hand side and is then hit from behind by a large tractor being driven onto the circuit. He died at the scene. Following a post mortem the medical cause of death was determined to be: 1a. Multiple injuries 1b Road traffic collision
5	**<u>CORONER'S CONCERNS</u>** During the course of the hearing 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. The TV recording of the event shows that as soon as the race is concluded the gate to the only entry and exit point is opened. Pedestrians (in using this term I include those working at the event and others) and several recovery vehicles then come through the gate. At the same time Stock Cars remain on the track some undertaking "doughnuts". There are many pedestrians moving around the track area whilst large recovery vehicles are moving, some at speed, onto the track. There is a complete absence of control of any pedestrians onto and those already on the track. There is no pedestrian walkway on the track and no designated pedestrian safe area. There is a complete lack of awareness of the risk to pedestrians on the track who are in very close proximity to large recovery vehicles. Urgent action is required to review when and how pedestrians should be allowed on the race track at any time during a race event. 2. Urgent action is required to ensure pedestrians on the track have clear protected walkways and safe areas away from large recovery vehicles. 3. Urgent action is required to review the risk assessment document to ensure it adequately protects any pedestrians that need to be on the track.

	4. Urgent action is required to review the prize giving procedure and to consider moving this to the "Public Area" as there appears to be no need for it to be undertaken in the middle of the track amongst moving vehicles. 5. Urgent action is required to consider the safety of staff working during the races and whether they should remain on the track given that they are completely unprotected should a vehicle in the race lose control.
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 5 March 2020. 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: • The Family • [redacted] • [redacted] • Birmingham Wheels • Birmingham City Council • WMP • Teng Tools Ltd • Brisca Formula 1 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	09/01/2020 Signature  Mrs Louise Hunt HM Senior Coroner **Birmingham and Solihull**