



Date: 29 December 2020
[REDACTED]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [REDACTED] - JM Nixon Ltd, Swinhoe Farm
Belford Northumberland

1. CORONER

I am Karen Lorraine Dilks **Senior Coroner for Newcastle and Acting Senior Coroner for North Tyneside Coroners**

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.

<http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7>

<http://www.legislation.gov.uk/ukxi/2013/1629/part/7/made>

3. INVESTIGATION and INQUEST

On 7 April 2016 I commenced an investigation into the death of Marian Elizabeth CLODE. The investigation concluded at the end of the inquest on 22 October 2020 . The conclusion of the inquest was

Accident

Medical Cause of Death

- 1a CARDIAC ARREST WITH ANOXIC-ISCHAEMIC BRAIN INJURY
- 1b NECK FRACTURES AND SEVERE SPINAL CORD INJURY
- 1c FALL (ATTACKED BY A COW)

II

4. CIRCUMSTANCES OF THE DEATH

On the 2 April 2016 Marion Clode, her husband, daughter and son in law and 2 grandchildren travelled to Pine Cottage, Swinhoe Farm, Belford, Northumberland for a 1 week holiday.

On the 3 April Mrs Clode and her family went walking on a recognised walking route from the farm. The family were unaware of the farmer's [REDACTED] plan to move cows and their calves from their winter shed into a field adjacent to a public bridleway. The cattle were assembled in a non secure holding area in preparation for movement. Some cattle broke loose from the holding area onto the public bridleway. Simultaneously Marion Clode and her family were returning to Swinhoe Farm via that same public bridleway. They had no warning either verbal or by signage and due to the topography of the area were unaware of the cattle coming towards them.

Marion Clode, leading the family group was attacked by a cow 3 times sustaining injuries that lead to her death on the 5 April 2016.

5. 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) Cattle movement being commonly undertaken in accordance with individual farmers "custom and practice" and in the absence of:

- a) formal plans for cattle movement (written or verbal)
- b) Contingency plans/strategies in the event of cattle breakout
- c) Specific planning in respect of the heightened risk associated with the presence of young calves and in the context of their first release from winter shed

(2) Cattle movement undertaken without appropriate measures in place to mitigate the risks of cattle breakout:

- a) Cattle held prior to movement in a holding area pen which was insecure. Cattle contained only by quad bike and trailer (driven by farmer) at the front of the herd.
- b) No warning to the public of impending cattle movement and the risks thereof either by temporary warning signage or farm staff placed at strategic points on the planned route to give verbal warning.

(3) Secure gate at the entrance to bridle way unable to be utilised due to direction of opening which with some limited alteration may have gone some way to mitigate the risk in this case.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you [REDACTED] 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 29 December 2020, namely by 23 February 2021. 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:

[REDACTED]

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.

29 December 2020

Signature

K. Dukes

for HM Senior Coroner for Newcastle upon Tyne