



**MR GRAEME IRVINE
SENIOR CORONER
EAST LONDON**


East London, Queens Road Walthamstow, E17 8QP

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 14892552

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. [REDACTED], Capital Karts Trading Ltd, 15 Cabot Square, Canary Wharf, London, E14 4QS [REDACTED]</p>
1	<p>CORONER</p> <p>I am Leanne Woods assistant coroner, for the coroner area of East London</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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/uksi/2013/1629/part/7/made</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 19 August 2021 I commenced an investigation into the death of Ruwaida Abdi Adan age 15 years. The investigation concluded at the end of the inquest on 13 October 2022.</p> <p>The jury found the cause of death was: 1a Hypoxic Brain Injury, 1b Asphyxiation</p> <p>The jury's conclusion was a narrative conclusion: <i>"No safety check ensured that Ruwaida removed her headscarf before getting into her go-cart. No daily mechanics' check was carried out on August 6, 2021. In Ruwaida's cart the plastic drive belt guard to the rear axel was absent and the rear seat shield was damaged. Both should cover exposed moving parts. Ruwaida's scarf became entangled in the moving parts resulting in her asphyxiation and her death on August 10, 2021."</i></p>

4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On 6 August 2021 Ruwaida, age 15, went karting at Capital Karts, Barking as part of a summer programme for young people arranged by Newham Council. On that day she was wearing a religious headscarf.</p> <p>The evidence at the inquest was that Ruwaida should have been instructed to remove that headscarf and checks should have been done, at various stages, to ensure she removed it.</p> <p>However, she entered the pit lane wearing the headscarf under the karting helmet and started to race whilst wearing her headscarf. This was not identified by staff at Capital Karts before she began karting.</p> <p>The jury made findings in relation to the condition of the kart. The evidence at the inquest was that a kart in that condition should not have been driven.</p> <p>Ruwaida's headscarf became entangled in the kart's moving parts. The headscarf was pulled tight around her neck leading to asphyxiation and ultimately her sad death.</p>
5	<p>CORONER'S CONCERNS</p> <p>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>Whilst I received evidence that the system at Capital Karts has changed so that a person wearing a headscarf is now required to remove the item in reception and that must be witnessed, I continue to have a concern that there is a risk of future deaths.</p> <ol style="list-style-type: none"> 1. I am concerned about the current system's apparent reliance on checks at the reception area, particularly when it comes to long hair, which obviously cannot be removed and so may be untucked from a suit or come out of a suit before karting commences. 2. A current race director, who was a race director on 6 August 2021, stated it was a regular occurrence that track marshals did not spot loose clothing or hair outside a race suit. He said that when he raised this with marshals he would notice an improvement but then see a lapse again. 3. CCTV of the pit lane from 6 August 2021 showed a number of people with long hair hanging loose outside the race suits. The duty manager said that this hair and Ruwaida's headscarf were missed but had no idea why this happened. 4. Capital Karts conducted spot checks and used 'mystery shoppers' as part of the supervision of staff. This system has been used since 2013, i.e. was in operation at the time of Ruwaida's death. 5. There was no evidence about changes to training and/ or monitoring of tracks marshals (as opposed to staff working in reception). 6. My concern is increased by the evidence of Capital Karts' managing director during the inquest. At various points in his evidence he said that, on 6 August 2021, his staff "did their job", followed their training and did the checks they were required to do prior to racing (or words to that effect). As a result of the evidence from the managing director, I have a concern about the nature of Capital Karts' understanding of, and commitment to, addressing the concerns identified in the inquest about the adequacy of checks on clothing performed by marshals
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you</p>

	[AND/OR your organisation] have the power to take such action.
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 19 December 2022. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons the family of Ruwaida Abdi Adan (via Leigh Day Solicitors), London Borough of Barking & Dagenham, Health & Safety Executive, CDOP and to the local director of Public Health who may find it useful or of interest.</p> <p>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.</p> <p>I may also send a copy of your response to any other person who I believe may find it useful or of interest.</p> <p>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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	<p>[DATE] 22 October 2022 [SIGNED BY CORONER] </p>