REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Rt Hon Mark Harper MP Secretary of State for Transport Great Minster House, 33 Horseferry Road, London. S1P 4DR and Transport Research Laboratory, Crawthorne House, Wokingham, Berkshire. RG40 3GA. [redacted]
1	**CORONER** Miss Lorraine Harris, Area Coroner, East Riding of Yorkshire and City of Kingston Upon Hull.
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 2nd September 2021 I commenced an investigation into the death of Donald Frederick HOOKER, aged 70 years. The investigation concluded at the end of the inquest on 20th December 2022. The conclusion of the inquest was Road Traffic Incident. Box 3 of the record of inquest read: On 26th August 2021, Donald Frederick HOOKER aged 70 years, was travelling on the Humber Bridge when the drive chain of his motorcycle broke. He collided with a vehicle as he drifted to the left causing him to fall off his motorcycle. His crash helmet came off during the incident and he sustained head injuries. Dr Hooker was transported to Hull Royal Infirmary where he died on 28th August 2021.

	His medical cause of death was recorded as: **1a** Multiple Traumatic Injuries **1b** Road Traffic Incident
4	**CIRCUMSTANCES OF THE DEATH** Dr Hooker was an experienced motorcycle user. On 26th August 2021 he was travelling home from work via the Humber Bridge. When the road conditions permitted Dr Hooker began to accelerate appropriately (he had been travelling at approximately 30 mph). He was in 4th gear. As he accelerated the drive chain on his motorcycle broke, and Dr Hooker appeared to drift into a vehicle travelling on his nearside. The collision cause Dr Hooker to fall from his motorcycle but as the incident occurred Dr Hooker's crash helmet came off. He sustained severe head and facial injuries. He was conveyed to Hull Royal Infirmary where he died on 28th August 2021. There were issues with the drive chain of the bike that were causative of the accident, however I had additional concerns regarding the loss of his motor cycle crash helmet.
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 could 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) This is the second matter that has been referred to my jurisdiction in recent months where a motorcyclist has lost his helmet during a collision. During evidence it was adduced that, although it is not a common occurrence, it is certainly not unusual for a motorcyclist's helmet to come off or to rotate during a collision. (2) The Forensic Collision Investigator was unable to explain the reason for Dr Hooker's crash helmet coming off. The chin strap was in place. (3) The Forensic Collision Investigator indicated that she had been unable to find any research or scientific data on why such incidents occur. (4) It was adduced in evidence that a kite safety mark may be checked by an instructor during motor cycle courses/tests but there did not appear to be a known check for ensuring a person has the correct size motorcycle helmet. (5) It was acknowledged that many people may now purchase motorcycle helmets over the internet and the sizing and fitting may not be appropriate. (6) I am concerned that without knowledge of why such incidents are occurring, or appropriate education of the riders, that more deaths may occur.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your department/organisation 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 15th February 2023. 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 • [redacted] (son) as a representative of the family • Transport Safety Commission, C/O PACTS, Clutha House, 10 Storey's Gate, Westminster London. SW1P 3AY [redacted] 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. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE]** **[SIGNED BY CORONER]** ***21st December 2022*** ***Lorraine Harris***