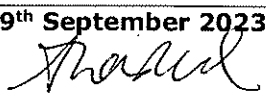
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]
1	**CORONER** I am Sabyta Kaushal, Assistant Coroner, for the coroner area of Derby & Derbyshire.
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** On 06 May 2021 I commenced an investigation into the death of John Frederick WRIGLEY aged 60. The investigation has not yet concluded and the inquest has not as yet been concluded.
4	**CIRCUMSTANCES OF THE DEATH** John Wrigley was an experienced Superkart racer who had been involved in motor sport for over 20 years. On 3rd May 2021 he attended an event at Darley Moor Kart Circuit. During a qualifying session, his kart left the track (reason unknown), travelled across wet grass and the left front wing of the kart impacted with a lorry tyre wall at between 66 and 71 mph. The kart rotated 360 degrees, then impacted on the left rear side wing and came to rest on the opposite side of the track. He was subject to huge forces and was flung out of the kart and landed on the track. There was no contact with any other Kart. A Marshall and another Kart racer witnessed the collision. Mr Wrigley received immediate medical care for his severe head injury and was taken to Derby Royal by land ambulance where he was pronounced deceased. His injuries were consistent with a high-speed impact. Police were not contacted initially. Following police involvement, police were in touch with the Motor sport association who had primacy to investigate the circumstances with police assistance. Following the post mortem the medical cause of death was determined to be: 1a. Head Injury
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) 1. The lorry tyre boundary wall remained in position on impact, moving only a few millimetres backwards; it did not absorb enough energy to slow the velocity of the kart. The lorry tyre barrier did not dissipate energy; evidence provided by those investigating the circumstances

	indicated that the primary function of the tyre barrier is to protect what lies outside the track e.g spectators and to contain the vehicle within the confines of the track. Energy dissipating or impact absorbing protection such as Airfence/Recticel - a closed cell barrier - was available to be placed in front of the tyre barrier but was not utilised ; the view was that shallow angle contact with a closed cell foam barrier would result in 'pocketing' i.e. cause injury rather than mitigate it. Super karts are not fitted with safety belts. This aspect, racer error and an inability to control the kart following such an error and loss of control was not taken into account when decisions were made regarding the placement of additional impact absorbing protection. Urgent action is required to review what additional type of energy dissipating or impact absorbing protection (e.g Airfence/Recticel) should be placed in front of the tyre barrier, where and in which circumstances. All risks, no matter how minimal, should be taken into account. Additional protection was available but not used. It may have reduced the potential severity of such an incident and prevented the death of a competitor or racer. 2. It had been raining and although water was not pooling on the track (which would have been a visible indicator to consider stopping racing on safety grounds) the grass area adjacent to the track was wet such that when Mr Wrigley left the track and moved onto the grass, the wet grass caused his kart to accelerate and collide with the tyre wall. Insufficient regard was given to the fact that the grass was wet when deciding if competitors should be allowed to use the track. Racer error and an inability to control the kart following such an error and loss of control onto grass was not taken into account when decisions were made regarding the use of the track by competitors. Urgent action is required to review the risk assessment of whether to start or stop a race due to wet weather.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your 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 November 23, 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 and to the following Interested Persons I have also sent it to [redacted] who may find it useful or of interest. 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	**29th September 2023**  **Sabyta Kaushal** **HM Assistant Coroner** **Derby & Derbyshire**