ANNEX A

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:** **1. [redacted], General Secretary of the Auto Cycle Union** **2. [redacted]**
1	**CORONER** I am James Puzey, assistant coroner, for the coroner area of Worcestershire
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 22 June 2023 HMSC David Reid commenced an investigation into the death of Christopher William Townsend, aged 43. The investigation concluded at the end of the inquest on 5 April 2024 which I heard. The conclusion of the inquest was that the medical cause of death was pneumonia as a result of multiple injuries sustained in a motor cycle accident and that Mr Townsend died as a result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** Christopher William Townsend died on 8 June 2023 at the Queen Elizabeth Hospital, Birmingham. He was involved in a motor accident on 4 June 2023 whilst participating in an organised grass-track motor-cycle and side-car race. He sustained multiple chest and abdominal injuries from which he did not recover
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) The risk assessment prepared for the grass-track event on 4 June 2024 was a downloaded proforma from the ACU publication "*ACU Requirements for Safety Precautions At All Track Race Events Held Under An ACU Permit*"(p.19 of 26). This document listed pre-populated control measures to address a list of pre-populated risks. The control measures were ticked "yes" or "no" by the organiser to indicate whether they were in place. The assessment of the level of that risk as high, medium or low was also pre-populated. This did not amount to a process that could produce an event

	specific risk assessment nor did it encourage organisers to record meaningful conclusions about controlling risk at their event. I was told by [redacted] that this was a pro-forma for grass track events and that more complex, event specific risk assessments were produced for other types of event. He also confirmed that the risk assessment pro-forma were under review by the ACU and he produced an example of a potential new pro-forma requiring significantly more individual assessment and input. I accept that the ACU is taking steps to address the inadequacy of the grass track event risk assessment process. (2) However, in my questions to [redacted] he confirmed that there is no requirement for organisers of events held under the ACU Regulations to prepare an event-specific Safety Plan at either National or Club events. There is such a requirement for ACU events held on an international/European permit (paragraph 3.26 National Sporting Code 2023). [redacted] confirmed that whilst it is not an ACU requirement to prepare such a plan for Club/National events it is open to organisers to do so. Appendix 3 of the ACU's publication provides an example of contents list of an event safety plan. (3) Planning for safety at motorsport events to which the public are admitted must be thorough, comprehensive and verifiable by being recorded. This allows organisers to record and disseminate safety arrangements for their events. The risks may differ in scale, but not substantially in nature, as between international and national/club events. (4) In my opinion, in the absence of such methodical planning and recording there is a risk of future deaths arising from the current arrangements for safety planning at ACU track race events. (5) I have carefully considered [redacted] evidence as to the reviews that are being undertaken by the ACU of their procedures and guidance. This was provided in his written evidence, his answers in oral evidence and in the letter from him dated 5 April 2024. I have also carefully considered the cogent submissions on behalf of the ACU by [redacted] of DWF, in particular as to Chief Coroner's Guidance Note 5 (November 2020), especially paragraph 7 thereof. Nonetheless, I remain of the opinion that in the absence of a requirement for a recorded safety plan for each event there is a risk that future deaths will occur. (6) Since the inquest [redacted] has provided me with statistics of injuries and fatalities at events governed by ACU rules and procedures. It does not allay my concerns but rather confirms that serious injuries and fatalities do occur at these events not infrequently.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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. 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] (General Secretary Auto Cycle Union and [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.
9	**April 2024** **HMAC James Puzey**