**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Secretary of State for Transport, [redacted]**<br><br>**2. Secretary of State for Culture, Media and Sport of the United Kingdom, [redacted]** |
| 1 | **CORONER**<br><br>I am Samantha Marsh, Senior Coroner for Somerset |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 16th September 2022, I commenced an investigation into the death of Simon Timothy Harding ("**Simon**"), aged 41. The investigation concluded at the end of the inquest on 22nd January 2025.<br><br>The conclusion of the inquest was Accidental Death, with the medical cause of death being recorded as:<br><br>Ia) Diffuse Axonal Injury, Subarachnoid Haemorrhage, Intra-Ventricular Haemorrhage, and Skull Fractures.<br>Ib) Fall from Motor Cross Bike<br><br>I recorded in box 3 of the Record of Inquest that:<br>"On the 10th September 2022 Simon Timothy HARDING, aged 41, was riding his Yamaha YZ250 moto-cross motorcycle around the Granfield Moto-Cross Track in Middlezoy when he has entered the Table Top jump at the end of the course. He has failed to successfully negotiate this jump as he had done multiple times throughout the day. Simon has become separated from his bike mid-air and landed on the ground with his bike landing directly on his head. He sustained catastrophic and unsurvivable head injuries as a result and, despite being air lifted to Southmead Hospital, where he underwent neuroprotective investigation and viable treatment, his injuries were ultimately unsurvivable and he died on the Twelfth of September 2022. In absence of any other external factors the accident appears to have been due to a misjudgement by a very experienced rider". |

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| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Simon was an experienced moto-cross rider, having ridden most weekends for recreation for many years (in excess of 20 years).<br><br>On the 10th September 2022 Simon had travelled with members of his family to the Granfield Westonzoyland Moto-Cross Track in Langport Road, Middlezoy, Bridgwater ("the Track"). Simon had ridden on the Track many times before.<br><br>On arrival those riding (which included Simon) had to fill in paperwork, sign a disclaimer and pay the fee to enable them to ride the Track. The Track was open to the public and so Simon accessed the Track with various other members of the public that day.<br><br>There was a 'kids/junior' track for younger less experienced riders, but all other riders were on the main track.<br><br>Simon rode, on a self-regulated basis; riding for give-or-take ten minutes and then coming off for a break of up to half an hour, before rejoining. All other riders at the Track appeared to be partaking on a similar self-regulated basis, although the periods of their ride versus rest were not ascertained and so it was open to riders to ride for longer should they wish.<br><br>Simon had completed numerous laps of the Track on that day without incident. The entire track included a final ramp/jump called 'The Table Top'. Riders accelerate up a ramp (made of earth), complete a flat section at the top before exiting via the downward ramp at the other end. In practice, due to speed, riders would project off of the flat elevated section and propel through the air before landing and rejoining the downward ramp.<br><br>Simon commenced his final circuit of the Track just before 13:00. There was nothing out of the ordinary on his final approach and acceleration onto the Table Top but it was visible to witnesses that almost immediately upon projecting into the air, Simon was in difficulty. He became separate from his bike mid-air and was therefore unable to push his bike away from him as he fell. He landed back on the track on his head, with his bike (a Yamaha YZ250) landing directly on his head. The force of the crush impact generated by the bike broke his helmet.<br><br>Simon sustained catastrophic head injuries as a result of the accident and was airlifted to Southmead Hospital in Bristol where the true extent of his head injuries were revealed. They were unsurviable and Simon died two days later. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. – |

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| | (a) There did not appear to be any method meaningful of rider registration before participants could access the Track. The only requirement placed on riders was provide their name and phone number before accessing the track. They were not required to provide details of a Next of Kin and/or medical information to assist paramedics of other professionals in safely and accurately treating them should they be unconscious and unable to communication and give this information for themselves. There appeared to be an assumption that those accompanying the rider on the day would know this information.<br><br>(b) There did not appear to be any kind of safety briefing for the riders before using the Track.<br><br>(c) The Track itself was largely unregulated. There was one operative 'Marshall' at site who was not wearing the high-vis clothing provided and remained confident that he could be clearly identified within the 4 acre site due to carrying a clip-board. At the time of the incident the steward was in the on-site burger van. Despite having a maximum number of riders at any one time, this was not checked or regulated due to the uncontrolled nature of Track access and absence of effective stewards. Adult riders of all skill sets with all speeds of bike could ride together. There was no attempt to segregate riders based on their skill, ability or power of their bike.<br><br>(d) Following on from the above point, there was one Marshall to cover the entire Track site which limited the ability to provide immediate and effective assistance in the event of an incident or accident at or on the Track.<br><br>(e) Staff at the venue (on the day of the incident, the one Marshall) had no first aid training. By pure chance, two spectators at the Track on the day were medically qualified professionals and coordinated the CPR between themselves until paramedics arrived.<br><br>Whilst I am satisfied on the evidence that the layout and organisation of the Track did not, in and of itself, contribute to Simon's death, the areas of concern highlighted above do, in my opinion, create an enhanced and unmitigated risk that death may occur, over and above the usual risk associated with this type of recreational activity.<br><br>It was highlighted during the Inquest that there is an absence of mandatory regulation and implementation of minimum standards that moto-cross venues must confirm to. Whilst various organisations exist that seek to promote and raise minimum standards for such venues, membership of these organisations and compliance to any standards is entirely optional and at the discretion of the venue operator. The owners and operators of the Track appears to be entirely unaware of any such organisations of Minimum Standards documents. I am concerned that without minimum standards for safety and risk management, there is a risk of future deaths. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. |

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| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **2nd April 2025**, I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br>(i) Simon's family;<br>(ii) The owners and operators of the Granfield Track<br>(iii) Somerset Council<br><br>I have also sent it to the following, who may find it useful or of interest.<br>(iv) The Auto-Cycle Union Ltd ("ACU")<br><br>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.<br><br>I may also send a copy of your response to any other person who I believe may find it useful or of interest.<br><br>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.<br><br>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response. |
| 9 |  <br><br>**5th February 2025** |