REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1 Secretary of State for Defence .**
1	**CORONER** I am Daniel SHARPSTONE, Assistant Coroner for the coroner area of Suffolk
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 the 12th May 2025 I formally resumed the Inquest into the death of Catherine Moore. I concluded the Inquest on the 4th September 2025 Catherine Moore died as a consequence of an RTC. On the balance of probabilities, inadequate repair and maintenance of the chronically damaged and defective steering of the MOD Land Rover contributed more than minimally to the RTC The medical cause of death was given as: 1a Traumatic brain Injury 1b Road Traffic Collision
4	**CIRCUMSTANCES OF THE DEATH** **Catherine Moore died on 3rd June 2022 following a road traffic collision between an MOD Land Rover and an HGV, causing the latter to cross the central reservation, crushing Catherine's car causing her fatal traumatic injuries** **The primary cause of the RTC on the balance of probabilities was the defective steering of the MOD Land Rover leading to the initial collision with the HGV. On the balance of probabilities, inadequate maintenance and repair of the MOD Land Rover contributed more than minimally to the defective steering. Accordingly, on the balance of probabilities, substandard maintenance and repair of the MOD Land Rover steering contributed more than minimally to Catherine's death.** **A Land Rover expert who examined the MOD Land Rover after the RTC noted that:** **At some stage the steering box has become misaligned with the steering wheel** **At some stage the steering wheel has been taken off and put back on the central position but without assessing the steering box** **There was no evidence the steering box had been opened and examined** **The inner race and bearings were damaged significantly affecting the steering** **The steering box was defective over a period of several thousand miles as evidenced by brinelling**

	The prop shaft on the Land Rover was badly worn and about to fail **The steering links were unevenly threaded** **The rear trailing link was bent** **There were different tyres on the front and back of the Land Rover** **The Joint Asset and Management System (JAMES), a system that oversees the governance of repair and maintenance of MOD vehicles, had deemed the MOD Land Rover FF (Fully Fit) for service at the time of the accident with all mandated inspections recorded as complete on the JAMES maintenance history**
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: **I found that:** **1. With regards to JAMES and its function supporting maintenance and repair of the MOD Land Rover:** **The terminology and descriptors on JAMES forms were very difficult to understand and it was unclear how data could be extracted for governance purposes.** **There are no details of the referrer if checks are needed with regards to the reasons for the referral.** **There is no check in the system allowing feedback to the referrer** **Limited reasons were given for entry into JAMES e.g. for failure of a vehicular part. This may limit the breadth of maintenance and /or repair with regards to any mechanical issues associated with the fault.** **There are limited details of work done other than task closed or fully fit i.e. few details on how a repair was done or what difficulties with the repair may have been encountered.** **There is little formal space on system for suggestions with regards to further work or maintenance on the matter attended to and repaired.** **There is lack of clarity on how to locate data and information on the maintenance and repairs.** **There was no evidence of ability or/to process or extract data from JAMES to** **facilitate systems and process audits** **The rationale and/or schedule in JAMES for some processes for e.g. ad hoc inspections was unclear.** **The user interface is unclear.** **The tabling and format are unclear.** **There was repetition of identical time and dates attached to different tasks.** **There is no formal searchable database e.g. for serious or recurrent issues and themes.**

	2. With reference to repair and maintenance of the MOD Land Rover: **There is no process with regards to inspection, checking, audit, feedback and testing of MOD vehicle maintenance and repairs** **There is no formal process for real time feedback to e.g. Motor Transport on ineffective/incorrect repairs/maintenance**
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 20, 2025. 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 **The family of Catherine MOORE via their solicitor** [redacted] I have also sent it to [redacted] who may find it useful or of interest. 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	**Dated: 26/09/2025**

Daniel SHARPSTONE
Assistant Coroner for
Suffolk