David Ll. Roberts LL.B

Her Majesty's Senior Coroner

North and West Cumbria

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **of Apartment 6, 42 Grove Road, Ilkley, LS29 9QF on behalf of The Fell Runners Association**
1	**CORONER** I am Robert Chapman, Assistant Coroner, for the Coroner Area of North and West Cumbria
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 2 May 2012 I commenced an investigation into the death of Brian Belfield, aged 63. The investigation concluded at the end of the Inquest on 26th September 2013. The conclusion of the inquest was: **The Cause of death was:** 1.a. Exposure and Hypothermia **The Narrative Conclusion was:** On the 29th April 2012 Mr Belfield registered as a competitor in the Buttermere Sailbeck Fell Race. He was a seasoned fell runner and had run this race in previous years. During the course of the race the weather became very poor with cold temperatures, high winds, driving rain, and poor visibility, particularly on the route between Causey Pike and Crag Hill.

	At some point between Sail and Crag Hill Mr Belfield left the race route and descended the fell-side at a place called Scar Crag. This was a difficult place to descend without good knowledge of the area, and especially in the poor prevailing weather conditions. There was no recognised track or path at this point to the bottom of the valley. It is likely that Mr Belfield took this route in order to shelter from the poor weather conditions and as a means of retiring from the race and returning to Buttermere. During the course of the descent Mr Belfield slipped on slippery moss falling and sliding a number of feet on his back, and in the process suffering abrasions and concussion. He came to rest in a pool of water from a stream, and it appears he became unconscious and died as a result of exposure and hypothermia. His death would have occurred shortly after his fall. After a search by a Mountain Rescue Team and an RAF helicopter he was found the next day. The organisers of the Race had miscalculated the number of runners and those who had retired and as a result they had not realised that Mr. Belfield was missing until his Wife had raised the alarm when he had not returned to their lodgings.
4	**CIRCUMSTANCES OF THE DEATH** As set out in the Narrative Verdict, above.
5	**<u>CORONER'S CONCERNS</u>** 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) No system was in place to ensure that an accurate record was kept, and referred to, of the participants in the race and those who had retired so that at the conclusion of the race it could be easily ascertained if anyone was missing. (2) The emphasis was on counting the total numbers of participants and retirees, rather than checking off the race numbers against an accurate record of the race numbers of those who had started. Thus, as happened in Mr Belfield's case an inaccurate count meant that there was no recognition that one runner was missing. (3) There did not appear to be any one single person, either the race organiser, or a nominated official in the race organisation, who had the responsibility to check the race numbers of those starting with the race numbers of those finishing, taking into account the race numbers of those who have retired. A single person should have had that responsibility. (4) There was no reliable means of communication between the race control and the marshals out on the fells so that each of them were aware of the number of

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participants in the race, those who had retired, and where they had retired.

(5) Thus it was not possible to "monitor" the runners around the course as required by the FRA Safety Requirement number 13. The higher the "risk" to participants in the race, because of terrain, weather conditions, length of the race etc, the higher the need for an effective means of communication, which should be planned into the preparations for the race

(6) When the marshal at checkpoint 3 notified race control of an inaccurate number of runners who passed through checkpoint 3 there was no consideration or investigation as to the reasons for the inaccuracies.

(7) There is potential for an element of "number confusion" if left over race numbers are used or reused. There should be an emphasis for allocated race numbers to start with the figure 1 rather than the figure 0

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe that the Fell Runners Association has 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 17 December 2013. 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]

[redacted]

I have also sent it to the following who may find it useful or of interest:

UK Athletics

Scottish Hill Runners

The Cumbria Constabulary

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	**21st October 2013** **Signed……** **D.Ll. Roberts – H.M. Senior Coroner** **For Mr. R. Chapman**