REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

- 1. Chief Executive, Royal Society for the Prevention of Accidents
- 2. Secretary of State for Transport

1 CORONER

I am Karen HENDERSON, Assistant Coroner for the coroner area of West Sussex

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 April 23rd 2014 I commenced an investigation into the death of Donald Spooner, 84 years of age. The investigation concluded at the end of the inquest on 23rd April 2014. The medical cause of death given was:

- 1a. Acute subdural haematoma and cerebral contusion
- 1b. Blunt head injury
- 1c.
- 2. Coronary artery atherosclerosis

My conclusion was: Accidental death

4 CIRCUMSTANCES OF THE DEATH

Mr Spooner was riding his motorised bicycle along a residential street when it caught the edge of a parked vehicle resulting in Mr Spooner being thrown from his bicycle. Despite resuscitation he died from the injuries sustained in the collision. Mr Spooner was not wearing a protective helmet despite the top speed of the bicycle being 15 MPH or greater when pedalling.

5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise for concern. In my opinion there is a risk that future death 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. That it is not compulsory to wear a suitable protective helmet whilst travelling on a motorised bicycle which can reach speeds in excess of 15 MPH
- 2. That Mr Spooner's injuries would have lessened and may have been survivable if protective headgear was compulsory for riding a motorised bicycle

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe RoSPA and the Secretary of State for Transport have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd June 2014. I, the Coroner, may extend this 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.

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 DATE: 5th May 2014

SIGNED: Karen Henderson