REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. Minister of Defence** **2. The Army**
1	**CORONER** **I** am Philip Alan Sharp, Assistant Coroner, for the coroner area of 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 the 11th June 2014 I commenced an investigation into the death of Sgt Mark Colin Foley who was born on the 3rd August 1982. The investigation concluded at the end of the inquest on 1st May 2015. The conclusion of the inquest was that Mark died from (1) Multiple injuries and his death was an accident
4	**CIRCUMSTANCES OF THE DEATH** On the 4th June 2014 at a local Army training area an RMWIK converted Land Rover was being driven by [redacted] It went out of his control due to his inexperience in driving the vehicle. The deceased who was commander of the vehicle and a front seat passenger was ejected from the vehicle as it left the road he having not put on his safety harness. He landed in front of the vehicle which proceeded to roll over him causing the fatal multiple injuries. I concluded that the accident was caused by the inexperience of the driver and Sgt Foley's death was caused by the failure to wear a safety harness. I concluded that Sgt Foley's failure to wear a safety harness was as a result of a combination of a discretion to given to commanders of vehicles not to wear safety harness, a failure to enforce standing orders by senior officers requiring the wearing of safety harnesses.
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.

6	The **MATTERS OF CONCERN** are as follows:- 1. Although the Army has taken action following a land accident prevention and investigation team report I was concerned although [redacted] was qualified to drive the vehicle he had insufficient experience in encountering difficulties in controlling the vehicle. 2. Although standing orders had been in place following a previous similar accident there was a practice among commanders of vehicles not to wear safety harnesses and failure to enforce such standing orders by senior officers.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you to take such action. I my view therefore you should consider: - 1. Some form of additional training for inexperienced drivers, under safe conditions, to test them in dealing with a loss of control of the vehicles in which they are learning to drive. 2. To devise a system and/or audit procedure to check that :- (a) Commanders are abiding by the rules on the wearing of safety harnesses and (b) Senior officers are enforcing and checking the compliance with the standing orders.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the Report namely by 27th July 2015. I, the Coroner, may extend the period. Your response to this and details of action taken or proposed to be taken setting out the timetable for action. Otherwise you must explain why no action is proposed.
9	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely: [redacted] the widow of Sgt Mark Colin Foley. 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 of the publication of your response by the Chief Coroner.

10	DATE : 1st June 2015 Signed by Coroner: Philip Alan Sharp P.A