REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Master of Foxhounds Association** 2. [redacted] **Partner of the Deceased** 3. **Health and Safety Executive** 4. **Chief Coroner**
1	**CORONER** I am Dr. Peter Harrowing, LLM, Assistant Coroner, for the coroner Area of Avon
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 26th February 2015 I commenced an investigation into the death of Ms. Scarlett Jukes age 54 years. The investigation concluded at the end of the inquest on 9th September 2015. The conclusion of the inquest was that the medical cause of death was I(a) Traumatic head injury, and the short-form conclusion as to the death was that of accidental death.
4	**CIRCUMSTANCES OF THE DEATH** On 28th January 2015 Ms. Jukes was participating in a Trail Hunting event with the pack of foxhounds. Whilst riding along a country lane Ms. Jukes' horse lost its footing following recent hail and she was thrown head first from the horse. During her fall her riding hat came off. Her head struck the tarmac and she suffered a severe traumatic head injury. She was administered first aid at the scene and was attended by the paramedics. Ms. Jukes was taken to hospital where she underwent surgery. However, despite all best efforts of the neurosurgeons she died on 14th February 2015. The riding hat worn by Ms. Jukes was a traditional hunt cap which did not have a chin strap and did not comply with current national and international safety standards for such protective headgear. The manufacturer's of the hunt cap state clearly on the cap that it is not intended to provide protection against personal injury and did not comply with relevant safety standards.
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. The **MATTERS OF CONCERN** are as follows. – (1) Members of the public who participate in such hunting events (i.e.'subscribers') are not required to wear protective head gear which complies with any relevant safety standards. (2) Hunt staff who are paid employees of each hunt and whose work can involve significant time riding horses are not required to wear head gear designed and manufactured to recognised safety standards. (3) The current recommendations of the Master of Foxhounds Association (MFHA), the governing body, published in October 2008 provides that hunt staff should be permitted to choose whether to wear a traditional hunt cap which does not comply with recognised safety standards or to wear a 'modern hat' which does comply with the required safety

	standards. (4) The MHFA should act to ensure that all hunt staff are required to wear protective headgear designed and manufactured to recognised national and international safety standards when riding horses during the course of their employment. (5) The MHFA should act to ensure that all members of the public, whether subscribers or otherwise, when participating in events under the auspices of the MFHA are required to wear protective headgear designed and manufactured to recognised national and international safety standards.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 22nd December 2015. 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 [redacted] partner of the deceased, and the Health and Safety Executive I shall send a copy of your response to [redacted] and the Health and Safety Executive. 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	**27th October 2015** **Assistant Coroner**