REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. M C Federation** **2. Portsmouth Motocross Club**
1	**CORONER** I am Grahame Antony Short, senior coroner for the coroner area of Central Hampshire
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 14 May 2014 I commenced an investigation into the death of BRADLEY MARK HARRY HOOPER aged 16 years. The investigation concluded at the end of the inquest on 14 July 2015. The conclusion of the inquest was that he died due to multiple injuries caused by a motor collision and I recorded a conclusion of Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** At about 10.28 on 11 May 2014 Bradley Hooper was riding a Honda motorbike in a club practice session at the motocross circuit at Down Farm Headbourne Worthy near Winchester. After mounting a flat topped jump near marshalling point 11, he came off his machine as the bike landed and was in the process of picking it up when he was struck from above by a Yamaha motorbike being ridden by another rider who had just gone over the same jump, but had no warning of his presence.
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. The evidence showed that the marshall at Point 11 had earlier been using his mobile phone to take photographs of passing riders and at the time of the incident was facing in the opposite direction to the direction of travel of the riders, so that he was unaware of Bradley Hooper coming off his machine and did not show a yellow flag until after the fatal collision. The MCF Code of Practice makes no reference to appropriate warnings which should be given to marshalls at briefings about the use of smartphones whilst practices or races are under way. 2. The marshall at Point 11 was aged 16 at the time of the incident and had only marshalled on one previous occasion. Although he claimed to have made this known to the Chief Marshall no action was taken to allocate him to a low risk position, notwithstanding the current club marshalling rules of Portsmouth Motocross Club which states that those aged 16-18 should be so allocated. I

	consider that Portsmouth Motocross Club should ensure that marshalls are allocated to positions based on the experience of each individual and that it should review its rules in light of the MCF Code of Practice (once that is updated) and its affiliation to MCF.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 15 SEPTEMBER 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 the Chief Coroner and to the following Interested Persons: [redacted] 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	**20 July 2015**