REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Ms Jill McDonald, Chief Executive Officer, Halfords Group plc**
1	**CORONER** I am Guy Davies, Her Majesty's Assistant Coroner for Cornwall and the Isles of Scilly.
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 30th September I commenced an investigation into the death of 79 year old Peter Norton. The investigation concluded at the end of the inquest on 9th March 2017. The conclusion of the inquest was that Mr Norton had suffered an accidental death from a fatal head injury sustained after falling off his bicycle whilst test riding it inside Halfords store in St Austell.
4	**CIRCUMSTANCES OF THE DEATH** Mr Norton attended Halfords St Austell on 21st September 2016 and asked the store assistant to check the gears on a recently purchased bicycle. The store assistant made the appropriate checks on the gears and then invited Mr Norton to try out the bicycle in-store. Mr Norton then rode the bicycle down the aisle from the rear of the store towards the checkout. He travelled some 40 yards before turning around an aisle. At this point Mr Norton fell off his bicycle and suffered the fatal head injury. Mr Norton was not wearing a helmet and there was no discussion about whether or not he should wear a helmet when cycling in-store. The inquest heard as follows • That it was common practice for customers to ride bicycles in-store. • That there was no policy regulating the riding of bicycles in-store. • That there was no policy requiring helmets to be worn when riding a

	bicycle in-store. • That there was no risk assessment concerning the riding of bicycles in-store. • The accident report was completed approximately a week after the incident following the visit of Health and Safety inspectors. The latter gave evidence that best practice required the recording of all accidents, including near misses. Mr Norton lost consciousness late on the 21st September and was conveyed by ambulance to Royal Cornwall Hospital. He never regained consciousness and died on the 24th September 2016. A post mortem identified the cause of death as a traumatic brain injury.
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 absence of guidance or policy concerning the riding of bicycles in-store. 2. The absence of a safe area in-store designated for cycling in-store. 3. The absence of guidance or policy concerning the use of helmets when cycling in-store. 4. The absence of risk assessments in relation to cycling in-store. 5. The application of best practice as regards accident reporting.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and Halfords Group plc have the power to take such action. I recommend Halfords takes the following action;- 1. Conducts a review of company policy and guidance concerning the riding of bicycles in-store 2. Considers whether there should be a designated safe area for cycling in-store. 3. Considers whether the use of helmets should be mandatory when cycling in-store. 4. Conducts a review of the appropriateness of risk assessments in relation to riding bicycles in-store. 5. Conducts a review of staff training on risk assessment and accident reporting.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 9th May. 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	**9th March 2017** **Guy Davies** **HM Assistant Coroner** **Cornwall & the Isles of Scilly**