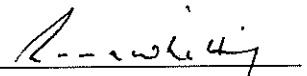
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: JULIE LENNARD, Chief Executive of Driver & Vehicle Licensing Agency, THE RT HON CHRIS GRAYLING MP, Secretary of State for the Department of Transport**
1	**CORONER** I am Emma Whitting Assistant Coroner for **Coventry**
2	**CORONER'S 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 23/09/2017 I commenced an investigation into the death of Tyrone Declan EVANS. The investigation concluded at the end of the inquest 5th July 2018. The conclusion of the inquest was Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** On 15 September 2017 at about 21.30 hours, the Deceased was driving a quad bike along the A444 in the inside lane towards Coventry city centre. The quad bike subsequently collided with the crash barrier on the near side of the road and then with the offiside of a Vauxhall Astra travelling in the same direction and in the same lane. Minutes prior to the collision, CCTV footage from Cyan Park Industrial Estate showed the Deceased performing a "wheelie" with the quad bike. The Deceased was not wearing a crash helmet but was not required by law to do so. At some point during the collision and most likely when the quad bike hit the crash barrier, the Deceased was thrown from the quad bike onto the carriageway causing him to suffer fatal injuries. .
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 medical cause of death was 1a Blunt Head Injury and the conclusion of the pathologist included the following: "I note the suggestion that he was not wearing a helmet and in my opinion the head injury pattern would support this. As a pathologist I am not in a postion to provide expert evidence on the issue of whether or not a helmet would have prevented his death but clearly when a death is caused by an isolated head injury, one has to suggest that wearing a helmet may well have altered the injury pattern and potentially severity, at least from basic principles". (2) I was informed at the inquest that the quad bike the deceased was driving was an off-road

	vehicle that had been adapted to use on the road. Yamaha UK confirmed to police that the vehicle had undertaken an Individual Vehicle Approval test by the Vehicle Operator Services Agency (VOSA) and had been issued with a registration number. (3) I was also informed at the inquest by the Collision Investigator that quad bike riders or passengers in England, Scotland and Wales are not required to wear crash helmets. (4) In light of the pathologist's comments, I am concerned that the absence of any legal requirement for quad bike drivers to wear crash helmets even where such bikes have been legally adapted for road use presents a continuing and potentially avoidable risk of deaths on our roads.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 10 September 2018 but 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	16/07/2018 Signature  Emma Whitting Assistant Coroner **Coventry**