**Her Majesty's Coroner**
**for the County of Dorset**

Senior Coroner: Rachael C Griffin

Assistant Coroners: Brendan J Allen, Grant E Davies
Richard T Middleton, Debbie S Rookes
Stephen J Nicholls, Victoria L Cook

18 January 2021

Our ref: [redacted]

**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

**THIS REPORT IS BEING SENT TO: National Rifle Association, National Small Bore Rifle Association**

## 1 CORONER

I am Brendan J Allen, Acting Area Coroner for The County of Dorset

## 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 17 October 2019 I commenced an investigation into the death of Michael Jonathan Woods.

The investigation concluded at the end of the inquest on 11 January 2021.

The conclusion of the inquest was that Mr Woods died by Suicide.

The medical cause of death was:

1a Traumatic Brain Injury

1b Gun Shot Wound to Head

1c

II

**4 CIRCUMSTANCES OF THE DEATH**

Michael Jonathan Woods died at Southampton Hospital on 9th October 2019. Mr Woods had been admitted to Southampton Hospital on 8th October 2019 after using a rifle to shoot himself while on a rifle range in Charmouth, where he was taking part in a shooting experience.

Mr Woods had contacted the Target Sports Centre ("the shooting range") on 8th October 2019, asking to arrange a tour of the site with a view to arranging a day out for his work colleagues. When he attended that afternoon, he requested availability of a "shooting experience" and was told there was availability on the 25 metre range for one hour of shooting, supervised by a qualified range officer. Mr Woods agreed, underwent a safety briefing and then proceeded to the 25 metre range together with one other participant and the range officer. It was towards the end of the hour of shooting, when, without warning, Mr Woods turned the rifle on himself.

Mr Woods' death was investigated by the police and the Dorset Council Environmental Health Department. Four recommendations were made to the shooting range by [redacted], the Environmental Health Officer investigating the death. All recommendations have been adopted by the shooting range. In addition, of their own volition, the shooting range will no longer take bookings from non-club members to shoot on the day they make the inquiry: bookings can only be for the following or subsequent days to allow a "cooling off" period.

**5 <u>CORONER'S CONCERNS</u>**

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) [redacted], who gave evidence at the Inquest, recommended that staff at the range undergo training in identifying signs of abnormal behaviour on the part of anyone wishing to take part in a shooting experience, to ensure that person is in the appropriate frame of mind to shoot. The shooting range have adopted the recommendation and identified a training provider, though the training itself has yet to be delivered due to covid restrictions. I heard evidence from [redacted], owner of the shooting range, that he is not aware of similar training being made available to staff at other shooting ranges. [redacted] went on to give evidence that he believes such training would be of value nationally, and could form part of a range officer's training.

(2) [redacted] also recommended that staff periodically carry out "emergency response" exercises to improve the staff response for this type of serious incident. Again, [redacted] confirmed the recommendation has been adopted and training identified, but not yet delivered due to covid restrictions. [redacted] gave evidence that such training would be of value nationally.

**6 ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe your organisations 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 16th February 2021. 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:

1. [redacted], wife of Mr Woods;
2. [redacted], mother of Mr Woods;
3. [redacted], brother of Mr Woods;
4. [redacted], sister of Mr Woods;

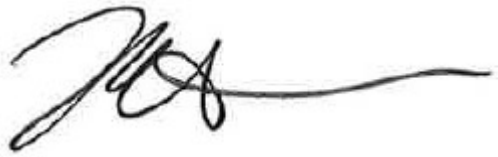
I have also sent it to [redacted] and [redacted] who may find it useful or of interest.

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**

18 January 2021

Signature 

Brendan J Allen HM Acting Area Coroner

for The County of Dorset

The Coroner's Office for the County of Dorset, Bournemouth Town Hall, Bournemouth, BH2 6DY
**T**. 01202 454910 **F**. 01202 454977 **E**. coroner.service@bcpcouncil.gov.uk DX 156942 Bournemouth 3