	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Department of Transport (Vehicle Design Approval and Licencing) The Ministerial Support Unit, Great Minster House, 33 Horseferry Road, London, SW1P 4DR**
1	**CORONER** I am Mr Andrew Haigh senior coroner for the coroner area of Staffordshire South
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 5 October 2012 I commenced an investigation into the death of Mitchell Harvey Clifton aged 7. The investigation concluded at the end of the inquest on 29 April 2014. The conclusion of the inquest was Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** Mitchell Clifton died at the scene of a road traffic collision at Landywood Lane, Cheslyn Hay on 3 October 2012. He was travelling down the footpath on a scooter and was struck by a van on an access way to a parking area. Neither Mitchell nor the van driver was aware of each other's proximity until it was too late.
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. – The van in question was a Mercedes Sprinter being used as a security van. As part of the adaptations for it to be a security van the size of the driver's door window had been reduced. The off-side wing mirror was standard. A reduction in the available view to the off-side may have been a factor why the van driver did not spot Mitchell. Perhaps you can kindly confirm that the design of this vehicle has been duly approved and consider if any further adaptations regarding either the window or mirror are appropriate.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 July 2014. 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] (Mother of the Deceased) • [redacted] (Father of the Deceased) • [redacted] (Traffic Process Office – Staffordshire Police) • [redacted] (Fentons Solicitors) • [redacted] (Clyde & Co Solicitors) • [redacted] (Local Safeguarding Board) • [redacted] (Clerk to Cheslyn Hay Parish Council) 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	**13 May 2014**  Andrew A Haigh HM Senior Coroner Staffordshire (South)