REGULATION 28*: draft* REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive – Tesco PLC** **Tesco PLC** **New Tesco House** **Delamare Road, Cheshunt,** **Hertfordshire, England** **EN8 9SL** **customer.service@tesco.co.uk**
1	**CORONER** I am S McGovern, Senior Coroner, for the coroner area of 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.
3	**INVESTIGATION and INQUEST** I opened an investigation on 28 January 2014 into the death of Ming Tsung CHEUNG, late of 176 Melbourne Road, Coventry. I concluded the inquest on 15 July 2014 and returned a conclusion that her death was road traffic incident.
4	**CIRCUMSTANCES OF THE DEATH** Miss Cheung was a student at Warwick University. She crossed Lynchgate Road, Coventry and was struck and killed by a lorry.
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. – I heard evidence that the point where Miss Cheung crossed the road was used by many pedestrians and had developed into an unofficial crossing point. Anecdotally there was some evidence of near-misses in terms of pedestrians being hit by vehicles. I heard evidence that a large Tesco sign obscured the view of Miss Cheung and the lorry driver. It may be that removal of the bottom wooden panels of the sign would be sufficient although I await to hear your response.

	Foy your information I also enclose a copy of a regulation report addressed to Coventry City Council concerning the same incident.
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 9 September 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 (a) Brindle & Yam solicitors for the family of Miss Cheung 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	**15th July 2014** **[** **Senior Coroner S McGovern**