REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sandwell Metropolitan Borough Council**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of Black Country.
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 30 June 2014, I commenced an investigation into the death of Lorraine Sheridan. The investigation concluded at the end of the inquest on 22 October 2014. The conclusion of the inquest was the deceased died on the 17 June 2014 from 1a. Multiple organ failure due to 1b) Multiple injuries due to 1c) Road traffic collision. I recorded a conclusion of Road traffic collision.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mrs Sheridan was involved in a road traffic collision on 30 May 2013 at 10.35am on High Bullen Road, Wednesbury. She was hit by an articulated lorry when she attempted to cross at a pedestrian crossing. 2. High Bullen Road is a dual carriageway consisting of two lanes and is subject to a 30mph speed limit. The carriageway in which the collision occurred is on the approach to the traffic island at the junction with the A462. The collision occurred at a pedestrian crossing approach to the traffic island. 3. The type of crossing is described as a pedestrian activated, traffic light controlled puffin crossing. There is a traffic island a short distance from the crossing if a driver is heading away from the M6 motorway. It is evident that if a vehicle approaches queuing traffic, then there is a risk that it may cause confusion to pedestrians at the pelican crossing who may be tempted to cross not appreciating that the lights were against them because there is no audible sound to indicate this. 4. During the inquest, evidence emerged that Mrs Sheridan had pressed a button to activate the pedestrian crossing sequence. A lorry had slowed down due to the queuing traffic and that she may have misinterpreted this and crossed not realising the lights were in favour of the lorry and a collision took place. 5. At the conclusion of the inquest, I asked the Police collision investigator to ascertain if there had been any further collisions at this location and upon receipt of this information, I would consider writing a report. 6. The Police have now provided me with a further report and have confirmed that there has been a second collision at this location. Sadly, on the 23 April 2013 three children were involved in a collision within the confines of the crossing. A vehicle had stopped in lane one and the children crossed and were struck in

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) There have now been two documented collision's at this location and in order to prevent similar collisions occurring in the future, the Police have suggested that an audible phase indication (red and green man) on the opposing side of the carriageway would reinforce the phase for pedestrians and make them far less likely to cross when it is unsafe to do so.
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 7 January 2015. 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, Mrs Sheridan's family and [redacted] West Midlands Police. 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	**12 November 2014**