REGULATION 28: 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:** Andrew Jones MP, Parliamentary Under Secretary of State for Transport, Department for Transport, Great Minster House, 33 Horseferry Road, London SW1P 4DR
1	**CORONER** I am Joseph Turner, Assistant Coroner for the coroner area of West Sussex
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 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 10 July 2014 the West Sussex Coroner commenced an investigation into the death of Giuseppina Incisivo, aged 79. The investigation concluded at the end of the inquest on 28 July 2015. The conclusion of the inquest was Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** Ms Incisivo was crossing North Street in the centre of Midhurst whilst the traffic was stop/start. She moved in front of a medium sized (27 gross tonnes) lorry, very close to the front, when the traffic suddenly moved off. She was run over and suffered catastrophic, traumatic injuries, dying at the scene within minutes. The driver's evidence was simply that he did not see her. Other witnesses suggested he could not have done so directly, and a reconstruction by the Sussex Police Forensic Collision Investigation Unit showed that Ms Incisivo would have come well under the height of the bottom of the windscreen. The vehicle had a front 'blind spot' mirror fitted and in good working order, but the evidence was that either a. The driver had visually swept the mirror (his evidence) but in the time delay before moving off Ms Incisivo had then moved in front of the vehicle, unobserved, or b. The size and shape of her image in the convex mirror, and lack of visual contrast between Ms Incisivo, a dark-haired, greying, lady around 5 feet tall, in light clothing, and the road surface, meant that she was insufficiently conspicuous (the Investigating Officer's expert opinion). In short, the driver, even using the mirror when she was in its reflection, would have found it very hard to distinguish Ms Incisivo.
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) That whilst the relevant EU Directives (2003/97/EC and 2005/27/EC) and associated legal requirements for some high-fronted goods vehicles require the fitting of a 'front blind spot mirror' (Class VI) of a certain size, shape and resulting view, the *actual* shape (convex) and *size* of such mirrors does not provide sufficient visibility of slow moving pedestrians (especially the elderly), or those not wearing highly visible clothing, especially when very close to the front of the vehicle. (2) That the lack of secondary 'front obstruction' warning systems, such as sensors which sound an audible alarm (similar to front parking sensors), or show a red/amber/green 'safe to move' light in the cab, or a forward facing camera with a screen in the cab, which would supplement the mirror means that over-reliance is placed on the mirror when, patently, it may not always serve its purpose. (3) That pedestrians, especially the elderly and children, whose height makes them difficult for drivers of such vehicles to observe may assume (wrongly) that a vehicle with a front 'blind spot' mirror 'must' see them when the reality is the opposite. (4) That, it seems, a general lack of awareness may persist of the risk posed when passing in front of such vehicles, and an assumption persist that because someone may be able to see the windscreen of the vehicle, that the driver 'must' be able to see them directly or indirectly. I am aware that other Coroners have reported similar concerns as regards older or other high fronted vehicles which need not have such mirrors. This is the second inquest I have heard into the death of an elderly person who, it seems, 'assumed' the driver would or must see them, directly or indirectly.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation, including the relevant vehicle agencies, 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 25 September 2015. I 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] (of Counsel), College Chambers, 19 Carlton Crescent, Southampton, Hants, SO15 2ET, representing the Incisivo family. [redacted] Kennedy's Law LLP, 25 Fenchurch Avenue, London EC3M 5AD, representing [redacted] the driver. 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	30 July 2015 [redacted]