REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Department for Transport, Great Minster House, 33 Horseferry Road, London SW1P 4DR**
1	**CORONER** I am James Newman assistant coroner, for the coroner area of Derby and Derbyshire
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 17th November 2014 I commenced an investigation into the death of Mr Richard Anthony Marshall TURNER, a 64 year old gentleman. The investigation concluded at the end of the inquest on 19th June 2015. I determined that Mr Turner had died as a result of a fat embolism resulting from rib and vertebral column fractures as a result of a reversing road traffic collision. The conclusion was of an accidental death.
4	**CIRCUMSTANCES OF THE DEATH** 1. On 13th November 2014, a light goods vehicle, a Mercedes Sprinter van, was engaged in courier duties in Cherry Tree Square, Tideswell. The vehicle was a standard vehicle, owned by the delivery company, and which had a fully enclosed rear. No reversing aids were fitted to the vehicle. 2. Cherry Tree Square, Tideswell, although a designated highway, had limited vehicular access and appears to be used regularly as a parking area. It was further described as an area of limited space, and where pedestrians would be a significant potential hazard. 3. At around 14:10 on 13th November 2014 the driver of the delivery vehicle returned to his vehicle, having made a delivery off Cherry Tree Square. There was then a 46 second delay between returning to the vehicle, and commencing a reversing procedure. During this 46 second window, Mr Turner entered Cherry Tree Square from the rear, and would have appeared briefly (for a matter of seconds) in the right wing mirror of the Mercedes Sprinter van. 4. Mr Turner suffered with marked Ankylosing Spondylitis (curvature of the spine) resulting in him presenting as almost constantly looking at the ground and therefore his visibility would have been markedly reduced. 5. The Mercedes Sprinter van proceeded to reverse slowly for a total of 19 seconds at low speed, before colliding with Mr Turner, and causing him to be thrown to the floor. 6. Following the collision, Mr Turner did not appear to be physically injured, although in any event emergency services attended. Initial assessments of Mr Turner's head, neck and spine by paramedics did not identify the injuries that Mr Turner had sustained, and Mr Turner wished to return home, a distance of some 80 metres from the scene of the collision. In order to continue the physical assessment the paramedics agreed to walk Mr Turner home, where he agreed to undergo more thorough examinations. 7. Having made it almost home Mr Turner collapsed and despite intensive resuscitation attempts passed away at 15:46 on 13th November 2014.

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) In evidence before me, forensic examination of the delivery vehicle found no mechanical defects that may have caused or contributed to the collision, although the evidence of both the driver of the vehicle, and the investigating officers identified a significant blind spot behind the enclosed back Mercedes Sprinter, which extended the width of the vehicle, and would have reached back almost to infinity behind the vehicle. (2) This is a form of vehicle, under 3.5tonnes, that is used nationally, in great numbers which would be expected to reverse in potentially confined areas, where pedestrians could be expected. (3) The evidence from both the driver and the attending officers were that had this vehicle been fitted with some form of reversing aid this collision may have been avoided. In particular the use of an audible reversing warning may have provided Mr Turner with an opportunity to avoid the collision, although the evidence of the driver and the attending officers of Derbyshire Constabulary was clear, and uncontested, that the use of a rear facing camera system would have prevented this fatality. (4) Whilst it is appreciated that there is currently no legislation to require the fitting of reversing aids, I note that a large fleet of light good vehicles are used daily around the United Kingdom, with significantly obstructed visibility and without the need to employ any reversing aids that could prevent similar deaths. (5) In terms of the figures relating to such deaths evidence was provided from the 'Mast Online' database indicating a total of 1475 incidents relating to good vehicles under 3.5tonnes. I am conscious, and concerned, that such figures only represent those incidents that occur on public highways, and that I personally am aware of at least one other similar incident in my jurisdiction, that occurring on private land would not be included in any such figures. On the evidence of the senior investigating officer, reported figures could only be the 'tip of the iceberg'. (6) I understand that this is not simply a national concern and reference was made to the following research papers/bodies in indicating that this appears to be of international concern, not solely regarding light good vehicles, but in cases, all vehicles. http://www.rospa.com/rospaweb/docs/advice-services/road-safety/parents/children-in-and-around-cars.pdf http://www.monash.edu.au/miri/research/reports/muarc321.pdf http://www.iihs.org/bibliography/topic/2065 https://dspace.lboro.ac.uk/dspace-jspui/handle/2134/8873 http://www.rearview.org.uk/ http://www.licencebureau.co.uk/wp-content/uploads/fleet-survey-report-part-1.pdf
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 24th August 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: 1. [redacted] 2. [redacted] on behalf of Yodel Ltd. 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	**26th June 2015**