HM CORONER
Central Lincolnshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Department for Transport**
1.	**CORONER** I am Paul Duncan Smith, Assistant Coroner, for the coroner area of Central Lincolnshire, Lindum House, 10 Queen Street, Spilsby, Lincolnshire, PE23 5JE.
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/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3.	**INVESTIGATION and INQUEST** On 13 July 2015 I commenced an investigation into the death of Robert Arnold Dearing, aged 49 . The investigation concluded at the end of the inquest on 21 July 2016. The conclusion of the inquest was that Mr Dearing died as a result of a road traffic collision, the medical cause of death being: 1a. Head Injury
4.	**CIRCUMSTANCES OF THE DEATH** 1. On the 3rd July 2015 at approximately 08.10am Mr Dearing was riding his pedal cycle along the C420 road, known locally as Sand Lane, Barkston, Grantham Lincolnshire. 2. He had almost reached the Sand Lane Railway Bridge, which carries the railway line across Sand Lane, the road passing under the bridge for a distance of approximately 20 metres. 3. The weather was bright and sunny, the sun being ahead of Mr Dearing, and slightly to his left hand side. 4. The immediate approach to the bridge had substantial hedges and mature trees which overhung the carriageway, causing substantial shadows. The area of the road beneath the bridge was in deep shadow. 5. Mr Dearing was wearing dark coloured clothing. 6. Mr Dearing was struck from the rear by a motor car being driven in the same direction of travel. The driver failed to see Mr Dearing prior to impact. 7. I received evidence that the driver offered by way of explanation for her failure to see Mr Dearing, that she had been distracted by the sun shining between her rear view mirror and sun visor, and also that he had been hidden in the shadows which were accentuated by the sudden change from bright sunlight to deep shade. At the time of the collision the driver was using a non-standard anti-glare visor fitted to the internal visor.

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) I received evidence that an examination of the motor car involved in this collision revealed that at the time of the collision it was fitted with a non- standard "Sunblaster" anti-glare sun visor which had been clipped onto the standard internal fitted visor. (II) The additional visor measured approximately 30cm x 10cm when folded. It was of bi-fold design, which allowed it to be opened down, to measure 30cm x 20cm. It was possible for the visor to be used with either one, or both sections of the visor in use, ie either single or double thickness. (III) At the time of the collision the driver had been using the visor folded, so that it was being used in "double thickness" mode. (IV) I received evidence that whilst there is specific legislation governing the light transmission qualities of vehicle windscreen glass, that the legislation does not currently extend to such devices, which are unregulated. I received evidence that there is currently no British Standard certification for such items. (V) I received evidence that there was a legal requirement that the vehicle windscreen should have a Visual Light Transmission (VLT) reading of not less than 75%. (VI) I received evidence that an analysis of the anti-glare visor demonstrated that if used in single thickness mode, it had a VLT of between 17.5% and 22.1%. When used in double thickness mode, as in this case, the VLT readings were greatly reduced, to between 3.9% and 4.2%. (VII) I received evidence that such results could be considered dangerous in that the driver's vision of the road ahead may be considerably obscured. In addition I received evidence that, if used in single mode, the fold line between the two sections may fall across the driver's eye-line and present a further impediment to the driver's field of view.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation 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 28 October 2016. 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] 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.
	30 August 2016 ..... **P D Smith** **Assistant Coroner**