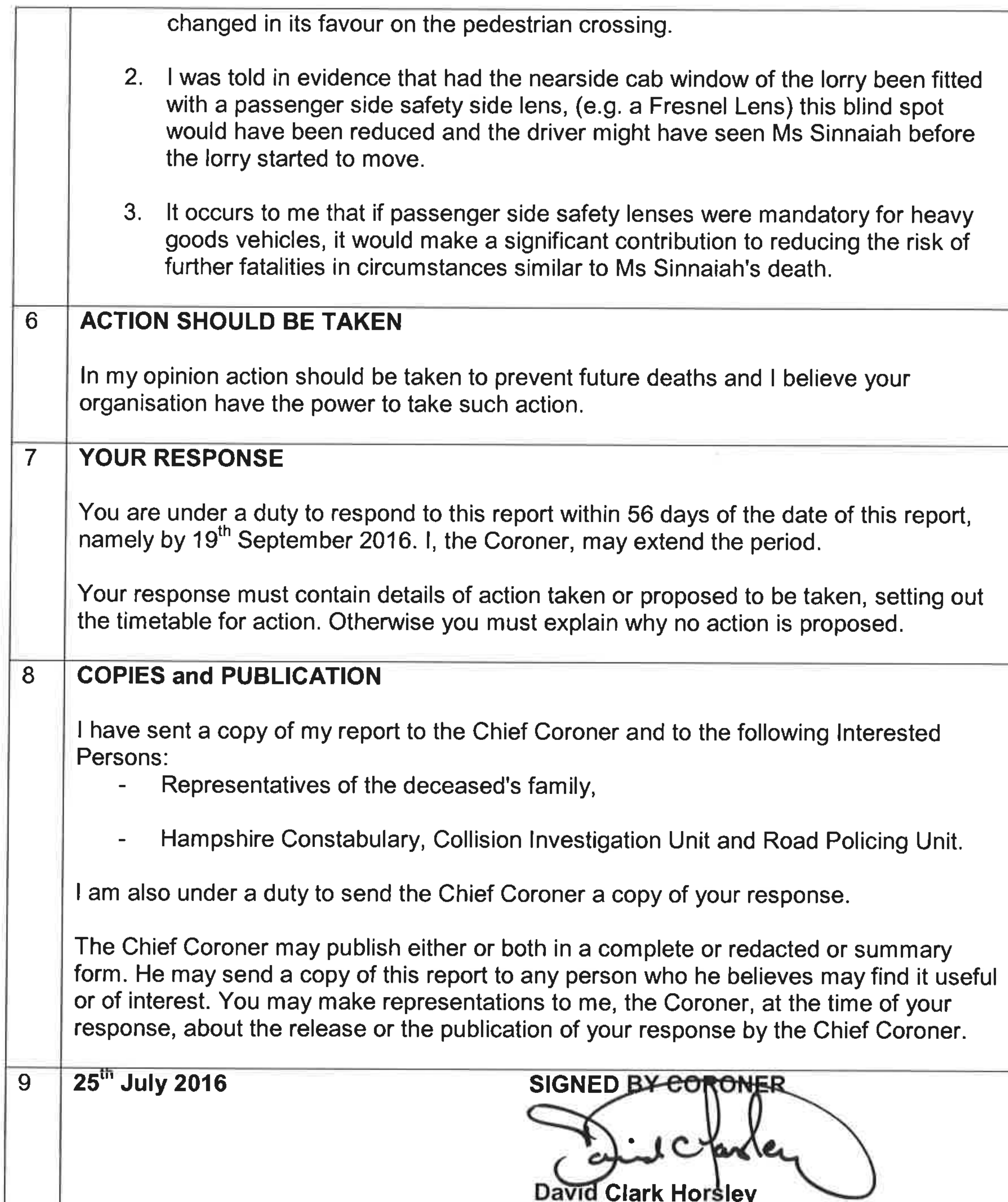
ANNEX A

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:** **Rt. Hon. C. Grayling, MP** **Secretary of State for Transport** **Great Minster House** **33 Horseferry Road** **London SWIP 4DR**
1	**CORONER** I am David Clark Horsley, senior Coroner for the Coroner area of Portsmouth and South East Hampshire.
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 1st February 2016 I commenced an investigation into the death of Yogalakshmi Sinnaiah, aged 58. The investigation concluded at the end of the inquest on 7th July 2016. The conclusion of the inquest was: 1. Medical Cause of Death: Multiple injuries. 2. Circumstances of Death: At about 13.55 hours on 26th January 2016, Yogalakshmi Sinnaiah was struck by a lorry whilst crossing Dragon Street in Petersfield. She sustained injuries that were instantly fatal. 3. Coroner's Conclusion as to Death: Death due to an Accident.
4	**CIRCUMSTANCES OF THE DEATH** See 3 above.
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. Whilst the mirrors fitted to the nearside of the lorry involved in the collision with Ms Sinnaiah met with all present construction and use requirements, they left a significant blind spot on the nearside of the vehicle and it is most likely that Ms Sinnaiah was in that blind spot when the lorry started to move after the lights



	changed in its favour on the pedestrian crossing. 2. I was told in evidence that had the nearside cab window of the lorry been fitted with a passenger side safety side lens, (e.g. a Fresnel Lens) this blind spot would have been reduced and the driver might have seen Ms Sinnaiah before the lorry started to move. 3. It occurs to me that if passenger side safety lenses were mandatory for heavy goods vehicles, it would make a significant contribution to reducing the risk of further fatalities in circumstances similar to Ms Sinnaiah's death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 19th September 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: - Representatives of the deceased's family, - Hampshire Constabulary, Collision Investigation Unit and Road Policing Unit. 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	**25th July 2016** **SIGNED BY CORONER** **David Clark Horsley**