	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, First Mainline**
1	**CORONER** Professor Christopher Dorries OBE, senior coroner for South Yorkshire (West)
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. (1) Where – (a) A senior coroner has been conducting an investigation under this Part into a person's death (b) Anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and (c) In the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action. (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it. (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner
3	**INVESTIGATION and INQUEST** In November 2013 I commenced an investigation and subsequently opened an inquest into the death of Mrs Sheila Bowling (aged 74). The investigation concluded without an inquest hearing on the 6th March 2015 when I sent a Certificate to the Registrar of Births and Deaths in view of the Crown Court hearing then concluded. Please see separate letter indicating the reason for the delay in forwarding this Regulation 28 report.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Bowling was crossing a road in Sheffield City Centre around 5.20pm on Wednesday, 6th November 2013. A [redacted] was driving a First Mainline public service vehicle on the 52 route. Mrs Bowling had virtually reached the far pavement when she was hit by the vehicle. She subsequently died of her injuries in hospital.
5	**<u>CORONER'S CONCERNS</u>** The investigation 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. –

	The investigation revealed that the vehicle was fitted with a so-called "Drive Clean System". It is understood that this measures the smoothness of the driving (thus promoting fuel efficiency) and records any sudden braking or steering movements. The learned judge hearing the criminal case at the Crown Court expressed concern about this and is reported to have said the following; "*The system his company employs encourages gradual acceleration and deceleration and resistance as far as possible from turning the steering wheel fiercely. It may have been possible had he used greater steering to avoid the lady who was in the last two metres of crossing the road. There was a clear error of judgement in that respect*". It is understood that whilst the learned judge [redacted] gave no opinion on the role that the monitoring system may have played in the tragedy he was keen for the coroner to exercise Regulation 28 in terms of a report. Notwithstanding the passage of time since this incident, First Mainline may wish to consider the operation of this monitoring system and/or whether the training thereon is open to any improvement.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 26th April 2017. I may extend the period upon application. 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: The family of Sheila Bowling Traffic Commissioners 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	**7th February 2017** ***Christopher P. Dorries*** **OBE** HM Senior Coroner South Yorkshire (West)