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:

1. Principal Engineer, Network Planning, Safety and Management, Highways and Engineering Division, Department of Place, 3rd Floor, Paderborn House, Bolton BL1 1UA

1 CORONER

I am M Jennifer Leeming, HM Senior Coroner for the Coroner Area of Manchester 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.

3 INVESTIGATION AND INQUEST

On the 19^{th} of February 2016 I commenced an investigation into the death of Thomas Moore Unsworth, aged 80 years. The investigation concluded at the end of the inquest on the 9^{th} February 2017. The conclusion of the inquest was:-

- Thomas Moore Unsworth died as a consequence of a Road Traffic Accident.
- The medical cause of Thomas Moore Unsworth's death was recorded as:-

1a Head Injury

CIRCUMSTANCES OF THE DEATH

On the 28th of January 2016 Thomas Moore Unsworth was a pedestrian crossing Great Moor Street in Bolton when he was hit by a bus turning left into Great Moor Street from Bradshawgate, Bolton.

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. During the Inquest evidence was heard that:-

The driver of the bus that came into collision with Mr Unsworth gave evidence that the nature of the junction into which she was turning together with the position into which pedestrians are guided to cross the road meant

that her view of such pedestrians was limited and in certain situations there was a "blind spot" in which she was unable to see pedestrians at all.

Police Officers likewise gave evidence that as vehicles were manoeuvring round this junction their driver's views of pedestrians were limited by the building line and then restricted by street furniture.

The area in question is presently under reconstruction giving an opportunity for these issues to be reviewed and addressed.

6 ACTION SHOULD BE TAKEN

In my opinion urgent action should be taken to prevent future deaths and I believe that 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 Wednesday 26th April 2017. 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. GMP Serious Collision Investigation Unit, Eccles Police Station
- 2. First Manchester Group, Wallshaw Street, Oldham OL1 3TR
- 3. c/o First Manchester Group

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.

Dated Signed Menifer Leeming, HM Senior Coroner

1st March, 2017 M Jennifer Leeming, HM Senior Coroner