

Tony Brown LLM
H M Senior Coroner
North Northumberland



17 Church Street
Berwick-upon-Tweed
TD15 1EE

Tel : 01289 304318
Fax : 01289 303591

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>[REDACTED]</p> <p>Legal Director Volvo Group (UK) Limited Wedgnock Lane Warwick CV34 5YA</p>
1	<p>CORONER</p> <p>I am Tony Brown, senior coroner, for the coroner area of North Northumberland</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 24th November 2017, assisted by a Jury, I concluded an Inquest into the death of Maurice Leslie Wrightson, a coach driver from Ashington, Northumberland, who died in France on the 16th April 2013 as the result of a road traffic collision. The circumstances of Mr Wrightson's death were summarised by the Jury as follows:-</p> <p>'On the 16th April 2013 at approximately 13.45 hours Maurice Leslie Wrightson was bringing 51 British passengers home to the United Kingdom on Departmental Road No. 211 between La Garde-en-Oisans and Bourg-d-Oisans approaching the hairpin bend number 21, when he realised the brakes were no longer responding. To stop the coach and not risk tipping into the ravine, he chose instead to crash into the rocks on the side of this bend, opposite the coach's path. When it hit the boulders near the steep bend number 21 the coach burst into flames and as a result Maurice Leslie Wrightson's death was pronounced at 14.45 hours on the same day'.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>As described in the above narrative.</p>
5	<p>CORONER'S CONCERNS</p> <p>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</p>

circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

During the hearing evidence was heard that Mr Wrightson was using i-shift automatic gears while driving the coach, and a foot retarder, in addition to the normal vehicle brakes during the long mountain descent.

The inquest heard from a former Depot Manager [REDACTED] that following Mr Wrightson's death, he checked with other coach drivers in the employment of Classic Coaches, Durham, at the time, as to their usual driving practice and found that their driving practices were equally divided. Some drivers engaged manual gears and others used automatic i-shift gears during mountain descents. Mr Shipley took the decision to instruct all drivers to use manual gears during long mountain descents.

Evidence was heard that driving uphill, an automatic gear system works on the principle of climbing with a low gear initially until the vehicle gains momentum and automatically steps up to the next gear as resistance lowers and speed increases. Conversely, going downhill the use of automatic gears would have less resistance and increased momentum, causing a need for additional braking. [REDACTED] informed the inquest that he had tried to clarify the position with Volvo as to the recommendations contained in the Vehicle Manual, which gave a clear recommendation as to the use of vehicle gears while going uphill but was silent as to any recommendation when going downhill. [REDACTED] said that in attempting to clarify the situation with the vehicle manufacturers, the reply he received was that drivers 'should follow the information or advice contained in the Vehicle Manual'.

The manufacturers (Volvo) had not been recognised as an interested person or invited to attend the Inquest because this was a point which arose during the hearing of [REDACTED] evidence at the Inquest itself.

[REDACTED] evidence was that the Volvo handbook wallet for the B12B and B12M produced in 2004 has a driver's handbook, operating instructions display booklet, operating instructions EBS booklet and operating instructions I-shift gearbox booklet which gives guidance only in relation to driving up a hill and the locking gear.

In respect of subsequent Volvo models the advice remains the same except that later dated manuals advise 'caution in respect of brake fade in long descents'. There is no warning that automatic mode is likely to exacerbate brake fade in long descents (such as at Alp D'Huez).


[REDACTED] told the inquest that he would at that time, as a PCV driver himself, have done exactly the same as Maurice Wrightson and used automatic mode. The Volvo manual gives no guidance to drivers for downhill driving such that automatic gearbox mode would be selected rather than manual by most drivers. Owners and drivers are reliant on the manufacturer to supply adequate instructions on the use of these technological advancements fitted to their vehicles.

The inquest does not apportion any blame or liability for the circumstances of deaths and is prevented by Sections 5 and 10 of the Coroners and Justice Act 2009 from doing so. However, it seems to me that the lack of information contained in the Vehicle Manual may lead to a lack of understanding or uncertainty, and there is a risk that this may lead to future deaths.

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ACTION SHOULD BE TAKEN

I believe that action should be taken to address the concerns raised by the

	circumstances of Maurice Leslie Wrightson's death.
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday 10th February 2018. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-</p> <p>[REDACTED]</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>DATE 13 December 2018</p> <p></p> <p>TONY BROWN HM Senior Coroner for North Northumberland</p>