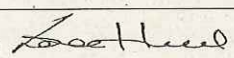
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] - Lorry Driver** **2. S & J Transport of Coleshill, Warwickshire – Employer of Lorry Driver** **3. Scania – Lorry Manufacturer** **4. Road Haulage Association** **5. Department of Transport**
1	**CORONER** I am Mrs Louise Hunt HM Senior Coroner for **Birmingham and Solihull**
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 17/10/2017 I commenced an investigation into the death of Suzanna Jayne Bull. The investigation was adjourned under S11 and Schedule 1 of the Coroners and justice Act 2009 pending the outcome of a criminal trial.
4	**CIRCUMSTANCES OF THE DEATH** <u>Introduction</u> This case surrounded the death of Dr Suzanna Bull, a pedal cyclist, who died as the result of a road traffic collision at around 16:00hrs on Monday 9th October 2017. The inquest was adjourned under S11 and Schedule 1 of the Coroners and Justice Act 2009 and a criminal trial concluded in October 2019 when the driver of the lorry was found guilty of causing death by careless driving. The employer of the lorry driver pleaded guilty to offences under the health and safety legislation. Since these proceedings it has been assessed by the Senior Coroner that there is insufficient reason to resume the inquest. However, it has been brought to my attention that there is a serious safety concern regarding the circumstances of the death which needs to be addressed. <u>Factual Circumstances</u> The circumstances of the collision are that Dr Bull was riding her pedal cycle along the Pershore Road in the direction of Birmingham City Centre, she was using the designated bus/cycle lane. Dr Bull was passed by [redacted] who was driving a 32 tonne lorry at a point adjacent to West Midlands Police Training Centre Tally Ho, the lorry then had to slow and stop at the junction with Priory Road for a red traffic light. Dr Bull approached the stationary traffic and proceeded towards the advanced stop line using the dedicated cycle lane, she advanced along the nearside of the lorry. The traffic lights turned to green and traffic started to proceed, Dr Bull was ahead of the lorry by a maximum of three bike lengths before the lorry started to catch her up. The lorry then began a left turn manoeuvre and struck Dr Bull dragging her under the front of his vehicle. Dr Bull died as a result of the offside second steered wheel passing over her prone body and trapping her beneath. Evidence in the criminal proceedings centred on an aftermarket dashboard tray which the lorry driver had placed on his dashboard which he then adorned with personal items including a satellite navigation device, an electric fan, ornaments and toys which then obscured his view to the front and nearside. See photo attached. When this table was fitted it created a huge blind spot and had the tray not been placed on the dashboard, Dr Bull would have been seen for at least 5 seconds. With the tray in place it is probable that she could not be seen by the lorry driver. Evidence was given in the criminal trial by DVSA and Scania Tamworth that the fitting of the aftermarket tray was deemed to be dangerous and with the table fitted the vehicle would undoubtedly have failed the MOT.

	There are no manufacturer details known about the table fitted to the lorry as it was taken from the storeroom at his employer's location and placed into his own vehicle, he was aware that the previous owner had purchased it from the internet to use in a Scania lorry but had since changed vehicles. The tray/table is not a standard fit item supplied by Scania. The Scania group do sell accessories for the vehicles they sell and some newer vehicles are now supplied with standard fit tray/tables however these are either hinged to fold away or are completely detachable and are not designed to be used when the vehicle is in motion. Please see the letter from [redacted] in supporting the concerns raised. Following a post mortem the medical cause of death was determined to be: 1a) MULTIPLE INJURIES 1b) ROAD TRAFFIC ACCIDENT
5	**CORONER'S CONCERNS** During the course of the investigation evidence has been provided to me revealing 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. The fact that the tray creates a blind spot may not be apparent to users. There is no warning on the tray to say that it can create a blind spot when fixed in place whilst the vehicle is moving. Consideration should be given to placing a clear warning on the tray that it should not be fitted. 2. There is no general warning to lorry manufacturers and haulage firms to advise against the use of such trays in a moving vehicle due to the blind spot it creates. Consideration should be given to sending out a warning to all manufacturers and users to highlight the concern. 3. There is no warning on the dashboard tray to say that it should only be fitted when the vehicle is parked up and stationary.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 24 January 2020. 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, the family and WMP. 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	29/11/2019

	Signature  Mrs Louise Hunt HM Senior Coroner **Birmingham and Solihull**