Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

National Police Chiefs' Council,
1st Floor, 10 Victoria Street,
London SW1H 0NN

1 CORONER

I am Andre REBELLO, Senior Coroner for the area of Liverpool and Wirral

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 31/12/2018 I commenced an investigation into the death of Anthony Carroll aged 70. The investigation concluded at the end of the inquest on 08 January 2020. The conclusion of the inquest was:

Road Traffic Collision

The medical Cause of death was found as:

Ia Multiple injuries

4 CIRCUMSTANCES OF THE DEATH – Found by the Jury

Anthony Carroll was a local, well-liked Liverpool man. He was on his way home from the Throstles Nest public house at 18:40 on 25/12/2018, having celebrated Christmas Day with his family earlier that day. Anthony headed Northbound on Scotland Road A59, Liverpool.

Having not used the pedestrian crossing immediately available outside the Throstles Nest, for reasons unknown, Anthony walked a short distance and crossed the carriageway, on to the central reservation, where he continued to walk along, heading Northbound.

A police vehicle Peugeot 308 in the local area, was responding to an emergency call, received at 18:48. Action took by this police officer was to action blue lights, and what he thought was sounding sirens- although sirens were not actually activated along with deploying blue lights-as well as increasing speed from 30 mph up to 63 mph to arrive at place of emergency as soon as possible, heading North up Scotland Road A59.

At that time Anthony had arrived on foot approximately 10 metres away from the second pedestrian crossing on Scotland Road, near Hopwood Street, in the central reservation. The police vehicle at this time was in lane 3, 190 metres away. Although the area was well lit here, Anthony was wearing dark clothing, carrying a red bag with him.

Anthony stopped and looked left, to check for oncoming traffic for 3 seconds, while standing on the central reservation, at which point the police vehicle was 190 metres away from him.

Anthony then steps on to the carriageway, still looking to his left, southbound, towards oncoming traffic. After being in the carriageway 1.3 seconds, Anthony was struck by the police vehicle, at 47 mph. The police officer driving the vehicle carried out an emergency stop in a split second, slightly swerving to his left in doing so, but unfortunately had already collided with Anthony.

Both police officers immediately got out of the vehicle to attend to Anthony, after radioing for paramedics. One officer attempted to resuscitate Anthony, and was assisted by an off-duty Emergency Medical Technician (EMT) who was on his way home from work. The EMT found Anthony to be unresponsive at this time.

A senior paramedic arrived on scene in 6-7 minutes, who performed CPR and advanced medical techniques on Anthony.

Anthony was put on a stretcher and taken by ambulance with blue lights on at 19:21, to the trauma centre in University Hospital Aintree, where he was pronounced dead at 19:40.
Under these prevailing circumstances, there was no opportunity for the collision to be avoided.
During the post mortem toxicology report, Anthony's blood alcohol level was found to be 308mg per 100ml.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

1. During the Course of evidence, it was apparent that the public might be under a misapprehension that police emergency vehicles responding to an emergency are limited to 20 mph above the designated speed limit for the Road has there been publicity that vehicles need to respond safely as quickly as possible. If not, is this under consideration?

2. During the Course of evidence, the police driver and the police passenger believed the sirens were activated and sounding. Analysis of the Siemens VDO Incident Data Recorder demonstrated that in the heat of the emergency both were mistaken and the sirens were not activated. Has a warning light in the cab been considered as a visual indicator or the lights and siren being activated been considered?

6 ACTION SHOULD BE TAKEN
In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 04 March 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 of Mr Carroll
Merseyside Police

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

Andre REBELLO
Senior Coroner for

Liverpool and Wirral
Dated: 08 January 2020