Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Driver and Vehicle Standards Agency
By email: [redacted]

1 CORONER

I am Jacqueline LAKE, Senior Coroner for the area of Norfolk

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 13/10/2017 I commenced an investigation into the death of Dudley Stanley HOWE aged 82. The investigation concluded at the end of the inquest on 25/03/2020. The medical cause of death was:

1a Traumatic Head and Chest Injuries
1b Road Traffic Collision

The conclusion of the inquest was: Road Traffic Collision

4 CIRCUMSTANCES OF THE DEATH

On 6 October 2017 Mr Howe crossed Station Road, Attleborough. The railway crossing barriers were lowered and traffic was stationary. Mr Howe walked in front of a DAF lorry and stopped. Traffic started to move forward and the lorry collided with Mr Howe who died as a result of his injuries.

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: I understand there is nothing to mandate that specific subjects are covered during HGV training, such as the use and positioning of Class VI (cyclops) mirror which shows the area immediately in front of the lorry, which would otherwise be outside the lorry driver's view.
Some training is provided in respect of use of such mirrors but there are some Industry bodies and Operators who deliver training who do not require all drivers to undergo a Safe Urban Driving or Vulnerable Road User Awareness Course.

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 20 May 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:

[redacted] (Spouse)
Director General - Department of Transport

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 Dated: 25/03/2020

J Lake

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Jacqueline LAKE
Senior Coroner for Norfolk
Norfolk Coroner Service
Carrow House
301 King Street
Norwich NR1 2TN