ANNEX A

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:** [redacted] CEO DHL Supply Chain UKI 251 Midsummer Boulevard, Milton Keynes, Bucks, England, MK9 1EA
1	**CORONER** I am Graeme Hughes, Senior Coroner, for the coroner area of South Wales Central.
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 7th January 2019, I commenced an investigation into the death of David Edwin BLINMAN. The investigation concluded at the end of the inquest. The conclusion of the inquest was Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- On the afternoon of 28.12.18, David Blinman was walking home, via Railway Terrace. Whilst on Railway Terrace, he has either been struck by a reversing articulated lorry, or fallen into its path, proximate to this manoeuvre. This has led to him being crushed by the rear wheels of the tractor unit. His death was declared at scene by the attending emergency services. The incident occurred at a time when he was located within the vehicle's blind spot. Mitigating measures to reduce the risk of collisions with pedestrians were not actioned at the time of the incident. They, and the associated/applicable risk assessment were, in any event, in conflict with Rule 202 Highway Code, as the driver could not have seen clearly whilst reversing, and this likely contributed to his death. The Inquest focused, inter alia, upon:- a. The events immediately leading to, and of the collision on 28.12.18 b. The adequacy of the 2015, 2017 and 2019 Delivery Point Risk Assessments (DPRA), and their causal significance to the collision, if any. c. Categorisation by the Risk Assessors completing the above of the types of vehicles to be employed to undertake deliveries to the Blandy Terrace NISA

	store, and the causal significance to the collision, if any.
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) DPRA's do not mandate discussion with and documenting of, by the Risk Assessor, the views and experiences of the store owner/operator, nor of the drivers regularly delivering to the store, in relation to any particular hazards, or concerns. The Risk Assessor may not, therefore, be sufficiently informed of material which might assist him, or her in completing an adequate risk assessment. (2) The mitigating/control measures set out in the 2015, 2017 and 2019 DPRA's do not adequately address the risks of vehicles colliding with pedestrians, in circumstances where the latter are located within vehicle blind spots. The measures, I understood from the evidence of the 2017 and 2019 Assessor, remain unchanged, and I believe, may well extend to all such DPRA's, and not limited to the Blandy Terrace delivery location. (3) 360 degree checks cannot be undertaken by a driver, whilst in the process of conducting a reversing manoeuvre, unless mitigating measures such as reversing cameras or a banksman are deployed (4) Risk Assessors should have regard to current applicable driving guidelines, such as here, Rule 202 of The Highway Code when assessing risk and completing the DPRA
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 7th April 2021. 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 family who may find it useful or of interest. The Road Haulage Association & The Royal Society for the Prevention of Accidents 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	24th February 2021 **SIGNED:** Graeme Hughes, Senior Coroner for **South Wales Central**