



**Paul D SMITH**  
**HM Acting Senior Coroner**  
**County of Lincolnshire**

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p>1. Driver and Vehicle Standards Agency</p>
1.	<p><b>CORONER</b></p> <p>I am Paul D SMITH HM Acting Senior Coroner for the coroner area of Lincolnshire, 4 Lindum Road, Lincoln, Lincolnshire, LN2 1NN.</p>
2.	<p><b>CORONER'S LEGAL POWERS</b></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> <p><a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a></p>
3.	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 30/06/2020 I commenced an investigation into the death of Christopher Lloyd TAYLOR, aged 49. The investigation concluded at the end of the inquest on 13/04/2021. The conclusion of the inquest was that Christopher Lloyd TAYLOR died as a result of Road Traffic Collision, the medical cause of death being:</p> <p>1a. Pelvic and upper leg injuries sustained in a road traffic collision 1b. 1c. 2.</p>
4.	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>1. Mr Taylor was a keen recreational cyclist and on the afternoon of 15 June 2020 was riding his cycle on the U130, a minor rural road running between the villages of Kingthorpe and Apley near to Wragby, Lincolnshire.</p> <p>2. The road was of tarmac construction and was wide enough for only a single vehicle. There were no road markings. The carriageway way was bordered by a large overgrown hedge.</p> <p>3. At a point near to 'Glad Wood' the carriageway turned through 90 degrees to the left for Mr Taylor.</p> <p>4. As Mr Taylor entered the bend he encountered an agricultural crop sprayer approaching from the opposite direction. Visibility through the bend was limited and the evidence suggested that the two vehicles would only have been visible to each other for a matter of seconds.</p> <p>5. Mr Taylor braked fiercely, falling from his cycle onto the ground where he was run over by the wheels of the crop sprayer causing fatal injuries.</p> <p>6. The evidence suggested that Mr Taylor was not seen by the driver of the crop sprayer prior to the collision.</p>
5.	<p><b>CORONER'S CONCERNS</b></p>



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	<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 circumstances it is my statutory duty to report to you.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <ul style="list-style-type: none"><li>(i) The driver of the crop sprayer sat in a cab at the front of his vehicle. It provided an elevated view of the road with full length windows to the front and both sides.</li><li>(ii) Directly in front of the driver was a steering wheel and an A pillar at each front corner of the cab.</li><li>(iii) To the right hand A pillar there was affixed a flat screen monitor. That was for use only when the crop sprayer was being used for agricultural purposes.</li><li>(iv) A police reconstruction established that the presence of the screen fixed created a 'blind-spot' in the drivers field of view extending several metres in depth.</li><li>(v) The driver of the crop sprayer had not seen the cyclist approach throughout the limited time he would have been in view. On balance that occurred directly as a consequence of the presence of the screen.</li><li>(vi) The screen had no function at all whilst the vehicle was being driven on the public highway and did not need to be on a fixed mounting.</li></ul>
6.	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>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.</p>
7.	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 20/07/2021. 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><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <ul style="list-style-type: none"><li>a) [REDACTED]</li><li>b) [REDACTED]</li><li>b) Lincolnshire Police</li></ul> <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>
	<p><b>Date:</b> 25/05/2021</p>



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A handwritten signature in black ink, appearing to read 'P D Smith'.

Paul D SMITH  
HM Acting Senior Coroner