Her Majesty's Coroner
for the County of Dorset

Senior Coroner: Rachael C Griffin

Assistant Coroners: Brendan J Allen, Grant E Davies
Richard T Middleton, Debbie S Rookes
Stephen J Nicholls, Victoria L Cook

19 July 2021

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Grant Shapps, Secretary of State for Transport

1 CORONER

I am Debbie Rookes, Assistant Coroner for The County of Dorset

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3 INVESTIGATION and INQUEST

On 25 November 2020 I commenced an investigation into the death of Sarah Lewis.

The investigation concluded at the end of the inquest on 19 July 2021.

The conclusion of the inquest was Road Traffic Collision.

1a Multiple injuries

1b

1c

II Fluoxetine Toxicity

4 CIRCUMSTANCES OF THE DEATH

On 16 November 2020, Sarah Lewis drove her car to Kennedy's Garage, Lynch Lane, Weymouth, for an MOT. She was standing on the pavement at the junction of Lynch Lane and McKay Close waiting for a taxi. A large goods vehicle was being reversed from Lynch Lane into McKay Close when Ms Lewis started crossing the road behind the lorry. The lorry had its reverse warning lights on and its reversing alarm was clearly audible over the background noise of the industrial estate but it is unclear why Ms Lewis did not hear or see these. The lorry driver did not see Ms Lewis in his mirrors. The lorry struck Ms Lewis at approximately 09.45 on 16 November 2020 causing multiple injuries which were fatal. A post mortem examination revealed a level of Fluoxetine in excess of the therapeutic range and it is unclear what affect this may have had on Ms Lewis.

5 <u>CORONER'S CONCERNS</u>

[redacted]

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) A Large Goods Vehicle was being driven which had reverse warning lights and a reversing alarm. The driver was assisted by 7 mirrors. A pedestrian was stood on the pavement and she was not seen by the driver. It is likely that the driver was checking his nearside mirror or the road around him when the pedestrian stepped out behind the reversing lorry which resulted in a complete blind spot once she was behind the vehicle.

(2) The evidence I heard is that it is not mandatory for Large Goods Vehicles to be fitted with a camera at the rear of the vehicle to assist drivers and prevent this blind spot. A lot of drivers complete journeys alone without a banksman to assist them in safely reversing.

(3) There is no legal requirement for vehicles to have a rear camera and yet this may prevent future deaths. At the very least it would prevent a large number of accidents.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you Grant Shapps 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 14 September 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 the Chief Coroner and to the following Interested Persons, [redacted]

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

20 July 2021

Signature 

Debbie S Rookes

Assistant Coroner for The County of Dorset

[redacted]