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:** 1. **Road Haulage Association, Roadway House, Bretton Way, Bretton, Peterborough, PE3 8DD** 2. **Office of the Traffic Commissioner & DVSA, 386 Harehills Lane, Leeds, LS9 6NF** 3. **DAF Trucks Ltd, Haddenham Business Park, Pegasus Way, Haddenham, HP17 8LI** 4. **Whitelock Plant Limited, Carleton Road, Skipton, BD23 3BT**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East)
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 29th November 2018 I commenced an investigation into the death of Dr Jonathan Edward Ball, aged 46. The investigation concluded at the end of the Inquest on 11th September 2019. The conclusion of the Inquest was death was attributable to a Road Traffic Collision in which Dr Ball sustained 1(a) Multiple skull fractures and 1(b) Traumatic head injury following a motor vehicle collision.
4	**CIRCUMSTANCES OF THE DEATH** On the evening of Saturday 24th November 2018 a DAF HGV lost power and came to a halt around 18:15 hours on the A647 Stanningley bypass near Pudsey, Leeds. This is a two lane dual carriageway subject to a 70mph speed limit. It was stationary in lane 1 for 41 minutes displaying hazard warning lights and amber cab beacons alongside the nearside crash barriers awaiting mechanical assistance. Dr Ball was driving a Skoda Motorcar and collided with the rear of the 32 ton stationary DAF HGV at a speed estimated to be between 50-60mph. Despite wearing a seat belt and the deployment of the air bag he sustained fatal injuries and was declared dead at the scene at 19:18 hours.
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) The HGV was not equipped with a device (such as a warning triangle) which the driver could have positioned some way before his stranded vehicle to warn oncoming motorists of the hazard presented by a stranded 32 ton HGV blocking one lane of a dual carriageway in darkness.

	(2) The HGV driver had not been trained or instructed to contact the emergency services to report the foreseeable hazard created by his stranded HGV on a dual carriageway at night. The HGV was there for some 41 minutes before the fatal collision occurred (although the Inquest heard evidence there were several near misses before then). It was likely that when a mechanic did arrive at the scene the HGV would have been there for a further period before it was repaired or could have been towed to a safe location. In consequence, the police had no opportunity to guard the scene, position safety barrier or warning signs to alert approaching motorists of the hazard. (3) The evidence of the other motorists on the A647 at the material time indicated that the rear offside hazard warning light was hard to see (or thought not to be working) thus giving the impression that the HGV was indicating to turn left (and thereby potentially confusing approaching motorists). In such circumstances there was no added resilience to the lights displayed, such as would have been provided by having duplicate indicator/hazard lights on the rear corners of the HGV. Given the arduous work of such vehicles and the propensity for the light to become dirty at the end of a working day, concern was expressed at the Inquest as to the danger which might be created in the event (a) the HGV broke down in a hazardous location and (b) the rear lights were not working or insufficiently conspicuous.
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 12th November 2019. 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: (1) [redacted] (deceased's partner) (2) [redacted] (deceased's wife) I have also sent it to: (1) [redacted] West Yorkshire Police Collision Investigation Unit (2) The Editor, Yorkshire Post Newspapers who may find it useful or of interest. 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	**Date:** 17th September 2019 **Signed by Coroner:** Kevin McLaughlin