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. [redacted]** **President** **Shimano Inc** **3-77 Oimatsu-cho** **Sakai-ku** **Sakai City** **Osaka 590-8577** **Japan** **2. Rt Hon Patrick McLoughlin MP** **Secretary State for Transport** **Department of Transport** **Great Minster House** **33 Horseferry Road** **London** **SW1P 4DR**
1	**CORONER** I am Ian Smith, senior coroner/area coroner/assistant coroner, for the coroner area of Stoke-on-Trent & North Staffordshire.
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 12 August 2013 I commenced an investigation into the death of Neil Andrew Blood, aged 42. The investigation concluded at the end of the inquest on 4 February 2014. The conclusion of the inquest was Accidental Death. The cause of death was given as 1a Chest injuries.
4	**CIRCUMSTANCES OF THE DEATH** In July 2013 the deceased and various members of his family went to Jersey on holiday. He had purchased a new pedal cycle shortly before the holiday and took it with him. He had done some cycling on the island. On 31st July 2013 he went for a ride on his bicycle accompanied by a family member. Shortly before 1.15pm they were cycling along the pavement adjacent to a road known as Commercial Building near to South Pier Shipyard, St Helier when the deceased appeared to look behind him briefly and then almost immediately afterwards his bicycle wobbled as he seemed to lose control, his feet becoming stuck in the cleats of the bicycle's pedals. The deceased was then observed to fall to its offside, off the pavement and under the side of a passing van and under the nearside rear wheel of the van. The deceased was treated promptly by local

	first aiders and paramedics but died of his injuries shortly afterwards at the General Hospital, St Helier, Jersey.
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. To Shimano Inc: I can do no better than to repeat the comments of my colleague, the Deputy Viscount of the Royal Court of Jersey, made in his letter of 30 January 2014 (copy attached). 2. To Department of Transport (UK): What oversight, control or legislation governs the supply of pedal cycle cleats and shoes, and what consideration has been given to the potential risks and dangers involved and what warnings should be supplied at the time of purchase?
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or 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 30 June 2014. 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 following recipients:- 1. Chief Coroner, Regulation 28 Reports, Chief Coroner's Office, 11th Floor Thomas More Building, Royal Courts of Justice, The Strand, London, WC2A 2LL 2. [redacted] (widow of the deceased). 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	H.M. Assistant Coroner for Dan Stewart Smith. Senior Coroner. Anthony Frederick Curzon.