REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, National Express West Midlands.**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 5 February 2018, I commenced an investigation into the death of Mrs Tipper. The investigation concluded at the end of the inquest on 19 September 2018. The conclusion of the inquest was a short form conclusion of: Road Traffic Collision The cause of death was: 1a Multiple Injuries b Road Traffic Collision c
4	**CIRCUMSTANCES OF THE DEATH** i) At 17:03 hours on Monday 22nd January 2018 a fatal road traffic collision occurred on the A4030 Bearwood Road, Bearwood, Birmingham. ii) The sun had set, light was fading, but it was dry and visibility was good. iii) A West Midlands Travel Volvo double decked bus, registered number BU51 RVM, was being driven in heavy traffic in a southerly direction along Bearwood Road by [redacted] towards the A456 Hagley Road. iv) The bus stopped near to the junction with Poplar Road, which was ahead and to its relative nearside. v) Mrs Tipper was crossing across the mouth of the junction of Poplar Road in a southerly direction, heading towards the carriageway of Bearwood Road. vi) It appears that Mrs Tipper was most likely in the blind spot of the nearside "A" pillar of the bus, as the traffic and bus have started to move. vii) Evidence suggests that as the bus continued to move forward and is likely to have been partially available to be seen in close relative proximity to the nearside "A" pillar of the bus. viii) The bus driver would only have been able to see her in his peripheral vision as they both moved in a southerly direction, unless he had specifically

	looked in the region of the nearside "A" pillar. ix) Evidence from witnesses suggests that once the bus had begun moving forward, the driver's focus was directed forwards. x) Mrs Tipper then collides with the bus and the nearside wheels of the bus have travelled over her legs causing severe crush injuries. xi) The bus was travelling at a speed of around 6 mph. xii) The driver has continued along Bearwood Road before coming to a halt at traffic lights with the A456 Hagley Road. Whilst stationary, members of the public have informed him there has been a collision. xiii) Sadly, Mrs Tipper later died in hospital as a result of the injuries she sustained.
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. Evidence emerged during the inquest that the driver either through training or discussion with work colleagues had developed a practice of only focussing directly ahead with minimal eye contact with other drivers when emerging from junctions. It appears this was done to so as not to give any other drivers an indication to pull out in front of his bus.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. 1. You may wish to consider whether further training or guidance is needed given the technique deployed by the driver maintaining minimal eye contact. My concern is that this may result in a distraction when observations need to take place when emerging from a busy junction.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by1 December 2018. 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; Family. 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	**3 October 2018** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**