MISS KALLY CHEEMA LLB
HER MAJESTY'S SENIOR CORONER
COUNTY OF CUMBRIA

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Driver and Vehicle Standards Agency ("DVSA"), The Ellipse, Padley Road, Swansea, SA1 8AN (for the attention of Mr Gareth Llewellyn, Chief Executive)**
1	**CORONER** I am Miss Kirsty Gomersal HM Area Coroner for County of Cumbria
2	**CORONER'S LEGAL POWERS** I make this report under Schedule 5 paragraph 7 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013: https://www.legislation.gov.uk/ukpga/2009/25/contents http://www.legislation.gov.uk/uksi/2013/1629/contents
3	**INVESTIGATION and INQUEST** On 22 March 2017, Ms Kally Cheema (HM Area Coroner for Cumbria, now Senior Coroner for Cumbria) commenced an investigation into the death of Miss Rebecca Alice QUAIL to whom I shall refer as Rebecca. The investigation into Rebecca's death concluded at the end of her inquest on 15 July 2019. Evidence had been heard over six days between 13 and 17 May inclusive and 31 May 2019. The conclusion of Rebecca's inquest was Road Traffic Collision. The medical cause of death was 1(a) Severe Blunt Force Head Injury.
4	**CIRCUMSTANCES OF THE DEATH** On 15 April 2017, Rebecca was driving her car in the southbound carriageway of the A6 towards Kendal. [redacted] was driving north in a Mercedes Sprinter van towing a trailer carrying a digger. Close to the entrance to Pink Quarry in Shap, the trailer detached from the van and continued on an onward trajectory. The trailer entered the southbound carriageway and collided with Rebecca's car. The nose of the trailer entered the engine of Rebecca's car. The boom of the digger entered the passenger cell of Rebecca's car. Rebecca sustained a number of injuries as a consequence. The inquest into Rebecca's death was held over 6 days and heard evidence from 5 experts and other witnesses. My findings of fact included that: 1. The design of the tow hitch / coupling head was in accordance with legal requirements (i.e. Regulation 55 of the Economic Commission for Europe of the United Nations Uniform Provisions re Mechanical Coupling Components) and was not contributive to the cause of the incident. 2. There was no structural failure of the tow hitch. 3. There was a foreign object within the interface between the tow ball and tow hitch / coupling head.

	4. The object in question could not be identified. It is likely to be metal or hard stone and between 1.5mm and 3mm thick. 5. How the object got into the interface cannot be determined. 6. The tow hitch could still be placed fully over the tow ball with the cup of the hitch encompassing the ball. However, the tow hitch was not fully engaged due to the presence of the foreign object. 7. There was no requirement on the operators to check within the tow hitch before starting the coupling process. There was no requirement on the operators to do anything other than a visual inspection of the tow hitch from a standing position. There was no national guidance to inspect the coupling from a close side on view. 8. Neither operator knew about the "Jockey Wheel Test". The experts' opinion was that this was not a 100% reliable check and that a visual check of the coupling should always be done. 9. The detachment has occurred at the point it did due to the unique topography of the A6. 10. Conservatively, the experts have over 100 years' experience between them. They have never come across a foreign object in a hitch and had therefore not come across the cause of a trailer detachment to be a foreign object within the tow hitch. 11. The collision was therefore tragically unique due to the presence of a foreign object in the tow hitch (itself unique) and the unique topography of the A6 at the incident location. 12. My determination included that the trailer detached due to a foreign object present between the interface of the tow ball and towing hitch. The presence of the foreign object meant that the towing hitch was not fully engaged but may visually appear to be so. The trailer coupling manufacturer (Indespension) and the trailer operator (T&K Gallagher Limited) have both taken steps to raise awareness of the possibility of a foreign object in the hitch and the importance of checks to ensure a coupling is fully engaged. Both have taken steps to disseminate that information to other operators but it is a concern that there may be operators who are unaware of the possibility of a foreign object in a coupler.
5	**CORONER'S CONCERNS** 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. There is a possibility that a foreign object may enter a tow hitch coupling. 2. This may cause the coupling not to be fully engaged. 3. This may not be apparent on visual inspection. 4. There appears to be no national guidance on inspections and checks. 5. Operators may not always ensure that the inside of a coupler is free from foreign objects. 6. Operators may not always ensure that whatever a towing mechanism is used, that it is fully engaged by way of a full visual inspection. 7. That conducting a Jockey Wheel test is a further indicator that the coupling head may not be engaged and operators may not be doing so.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, the DVSA, has 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 13 September 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: [redacted], Rebecca's father. [redacted] of Butterworths Solicitors, Solicitor for [redacted] (Rebecca's partner), Ms [redacted] (Rebecca's mother), [redacted] (Rebecca's brother) and [redacted] (Rebecca's sister). [redacted] of Keoghs Solicitors, Solicitor for [redacted]. [redacted] of Clyde & Co LLP, Solicitor for [redacted]. [redacted] of Hill Dickinson LLP, Solicitor for T&K Gallagher Limited [redacted] of DAC Beachcroft Claims Limited, Solicitor for Indespension Limited [redacted] of Cumbria Constabulary (the Constabulary being an Interested Person) I have also sent it to the following who may find it useful or of interest: *Not applicable* 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	18 July 2019 Kirsty J Gomersal Miss Kirsty J Gomersal HM Area Coroner County of Cumbria