Karen Dilks
Senior Coroner for the City of Newcastle upon Tyne

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Newcastle upon Tyne City Council, Legal Services, 5th Floor Civic Centre, Newcastle upon Tyne, NE1 8QH (Ref: Tracy Quinn)**
1	**CORONER** I am Karen L Dilks, Senior Coroner, for the Coroner area of Newcastle upon Tyne.
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 8 February 2018 I commenced an investigation into the death of Pauline Howell, date of birth 30 May 1939, aged 78 years. The investigation concluded at the end of the inquest on 3 June 2019. The conclusion of the inquest was: Accidental Death Medical Cause of death: Head Injury.
4	**CIRCUMSTANCES OF THE DEATH** On 5 February 2018 in Newcastle upon Tyne City Centre; Pauline Howell, a pedestrian, walked in an Easterly direction on the North pavement of Newbridge Street West towards the pedestrian crossing at the junction with John Dobson Street. She continued walking in an Easterly direction on to the pedestrian crossing at the junction, in contravention of the pedestrian phase of the traffic lights ahead of her.

	A single-decked bus travelling East on Newbridge Street West, at the junction with John Dobson Street turned left to travel North. The bus struck Pauline Howell causing injuries which resulted in her death. In the opinion of Collision Investigators the design/layout of the junction was a significant contributory factor in the events that occurred, in that: The proximity of the crossing to the junction, combined with the "tight" nature of the left-turn-manoeuvre, allowed no opportunity for the bus driver to identify the pedestrian hazard and/or take action to avoid a collision. The evidence confirmed a previous death from a similar collision at the said junction.
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 could 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 risk of pedestrian error at the John Dobson Street crossing is foreseeable. (2) The crossing is situated close to the junction. (3) The crossing is situated on a busy bus route. (4) The Junction is "tight" and challenging for public service vehicle drivers to negotiate. (5) The design/layout of the junction/crossing allow no margin for error by either or both pedestrian and driver. (6) The deaths of two pedestrians resulted from injuries sustained whilst crossing this junction in similar circumstances and the risk of future deaths continues.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/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 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: • Northumbria Police Collision Investigation Unit • [redacted] (daughter) 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	**9 August 2019** **Signed by Karen Dilks, (Senior Coroner)**