	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** (1) Rt Hon Grant Shapps MP, Minster For Transport, Department of Transport. (2) Drivers and Vehicle Standards Agency.
1	**CORONER** I am Mr James Bennett HM Area Coroner for Birmingham and Solihull.
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 19/04/2018 I commenced an investigation into the death of Mollie Matilda Gifford. The investigation concluded at the end of an inquest on 29th September 2020. The conclusion of the inquest was: 'Died from unknown causes after being admitted to hospital with trauma caused during a road traffic collision.'
4	**CIRCUMSTANCES OF THE DEATH** On 16 March 2018 Mollie was waiting at a traffic light controlled pedestrian crossing on Bromford Lane. A large goods vehicle, travelling towards Erdington, approached from the nearby junction with Washwood Heath Road and came to a halt 4 meters beyond the stop line. The cab had standard class 5 and 6 mirrors to assist the driver with visibility around the cab whilst stationary. It is unknown how close Mollie was to the cab as she crossed the road, but the closer she was the less visible she would have been to the driver. Mollie was walking slowly and was in front of the cab when the lights changed to green. The driver was unaware of Mollie and drove into her as he pulled away at slow speed. Mollie was admitted to Queen Elizabeth Hospital. She had suffered significant rib fractures, including a flail segment, and an associated haemothorax. She required a total right arm amputation following severe comminuted displaced fractures to her arm and hand. She had a number of complications including intermittent atrial fibrillation, breathing difficulties, a blood clot in her remaining left arm, and she suffered a small stroke. By 26 March there was some improvement in her condition, she was moving both lower limbs and remaining upper limb, and was alert and co-operative. On 28 March she was transferred to a general ward. However, she became symptomatic of a chest infection and deteriorated, dying at 9.50pm on 29 March. A standard post-mortem was performed and offered a cause of death relating to the trauma caused by the collision. There was no examination of the brain and no histology of the lungs. Two forensic pathologists conducted a paper review and disagreed with the stated cause of death. Whilst they felt the chest was the most likely cause of death, they could not say so with certainty. Therefore, the cause of death and role of the collision remains unknown. The opinion of the forensic pathologists who conducted a paper review was that the medical cause of was 'unascertained'.
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.

	I heard evidence from [redacted] a forensic collision investigator of 15 years' experience. Mr [redacted] previously served for 23 years as a police officer involved in road traffic investigation and reconstruction – for the last 5 years he was in charge of a police collision investigation unit. Mr [redacted] explained that the lorry cab was fitted with standard class 5 and 6 mirrors. He estimated in his career he had been involved in around 150 collisions between lorries and other road users and pedestrians where the class 5 and 6 mirrors did not provide the cab driver with adequate vision. The mirrors are convex and therefore even when clean provide a distorted view, but as they are prone to collect road dirt and spray, the distortion is easily amplified, making it difficult for cab drivers to see movement and colour. Some cab drivers will have a false sense of security about the ability of class 5 and 6 mirrors to provide a comprehensive view of other road users and pedestrians around the cab when stationary. Mr [redacted] went on to explain that camera units are available on the market to stream live footage of around the cab to the driver on a screen. Camera units offer a clearer view, are not subject to the same distortion as class 5 and 6 mirrors and it is easier to pick out movement and different colours. My ongoing concern is that standard class 5 and 6 mirrors create an avoidable risk cab drivers will not see other road users and pedestrians in close proximity to the cab when stationary.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of today's date, namely by 15 December 2020. 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) Mollie Gifford's next of kin. 2) [redacted] – West Midlands Police. 3) [redacted], [redacted] and [redacted]. I have also sent it to the following who may find it useful or of interest: 4) [redacted] – Viewpoint Investigative Services. 5) Road Haulage Association. 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	30/09/2020 Signature  Mr James Bennett HM Area Coroner Birmingham and Solihull