REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **Grant Shapps** **Great Minister House** **Horseferry Road** **London** **SW1**
1	**CORONER** I am **PENELOPE SCHOFIELD**, senior coroner, for the coroner area of **WEST SUSSEX**
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 11th February 2020 I commenced an investigation into the death of James McKeough. His death occurred following a road traffic collision on 3rd February 2020. . The investigation was concluded with the Inquest being held on 6th December 2021. At the end of the Inquest, I concluded that James McKeough died following a Road Traffic collision. At the conclusion of the Inquest, I indicated that I would be making a Regulation 28 report addressing concerns that were raised at the Inquest regarding the current standard of lighting and position of this lighting on Slurrykat and similar tankers.

4	**CIRCUMSTANCES OF THE DEATH** On Monday 3rd February 2020, James McKeough was riding his motorcycle south on the A29 at Bury Hill, near Arundel. He came up behind a tractor towing a Slurry tanker at the top of the hill, travelling in the same direction. The tractor was indicating to turn right. It appears that Mr McKeough was hidden from the tractor driver's view and it seems that Mr McKeough did not see the tractor lights indicating. As the tractor turned right Mr McKeough collided with the offside of the tractor sustaining fatal injuries.

5	**CORONER'S CONCERNS** During 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. The positioning and size of of the rear mounted flashing LED lights on the Slurrykat and other types of similar trailers. 2. The fact that these lights emitted a brighter light than the right or left turn indicator light therefore masking the indicator lights. 3. These rear flashing lights are the same colour as the indicator lights. 4. The indicator light seems to get lost amongst the other flashing lights or can be misinterpreted as an additional non directional warning lamp. 5. On this particular trailer (SlurryKat) the indicator lights are at the same height as the indicators. It was found that this issue may have been a contributing factor in Mr McKeough's death as it appears he did not see the right indicator flashing.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 **2nd March 2022**. 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] [redacted] Forensic Crash Investigators – Sussex Police 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	**Date 9th December 2021** **Penelope Schofield, Senior Coroner**