SCHEDULE 5 PARAGRAPH 7, CORONERS AND JUSTICE ACT 2009,

REGULATIONS 28 & 29, CORONERS (INVESTIGATIONS) REGULATIONS 2013

REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: 1. [redacted], **UK Manager, UPS, Forest Road, Feltham, Middlesex, TW13 7DY** 2. [redacted], **President and CEO, Mercedes-Benz UK Limited, Delaware Drive, Tongwell, Milton Keynes, Buckinghamshire, United Kingdom, MK15 8BA**
1	**CORONER** I am Oliver Longstaff, HM Area Coroner for the Coroner area of West Yorkshire (Eastern)
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 08/01/2021 I commenced an investigation into the death of Michael Shuttleworth, born 20/02/1936, died 01/01/2021. The investigation concluded at the end of the Inquest on 19/07/2022. Mr Shuttleworth's medically certified cause of death was 1a) Head and chest injuries complicated by Covid-19 Associated Bronchopneumonia; 1b) Road Traffic Collision (Pedestrian); 2) Chronic Obstructive Pulmonary Disease and Frailty of Old Age. The conclusion of the Inquest was that Mr Shuttleworth's death was due to a road traffic collision.
4	**CIRCUMSTANCES OF THE DEATH** Mr Shuttleworth sustained his ultimately fatal head and chest injuries at about 1655h on 05/11/2020 when, as he was crossing Bridge Street in Huddersfield, he was struck and knocked over by a Mercedes Vario Box Van, registration number [redacted] with the number [redacted] painted on its bonnet, which was turning right into Bridge Street form Lockwood Road. The van was owned by UPS and was being driven by UPS's employee [redacted] in the course of his employment with UPS as a delivery driver. Two matters of fact were found to have caused the collision: first, Mr Shuttleworth stepped into the road at a pedestrian crossing which was showing a red light against him; second, [redacted] did not see Mr Shuttleworth before striking him and knocking him over.

	Pursuant to ss. 5(3) and 10(2) of the Coroners and Justice Act 2009, I did not express an opinion or record a conclusion as to the respective proportions in which the causative facts contributed to the accident and to Mr Shuttleworth's death.
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) [redacted] who was suspended by UPS the day after the collision and dismissed by them shortly thereafter, gave evidence that his view from the van when making right turns such as this one was obscured by a large blind spot. (2) An independent Forensic Collision Investigator ("FCI") gave evidence that, when sitting in the driver's seat at the position [redacted] had adjusted it to, there was a large blind spot to the driver's offside, which may have masked the presence of Mr Shuttleworth at certain points of the right turn manoeuvre. (3) The FCI gave evidence that this blind spot area was due to the driver's offside "A" post and rear-view door mirror assembly and was further affected by the driver's sliding door frame which when closed increased the blind spot area. (The FCI said anecdotally, and not as part of his evidence, that he understood that this particular configuration of the Mercedes Vario Box Van was unique to vans supplied by Mercedes to UPS.) 4) The FCI gave evidence that, using [redacted] van, he was able to reconstruct at the scene a scenario whereby a pedestrian crossing Bridge Street as Mr Shuttleworth was completely masked by the van's mirror assembly, "A" post and door frame. 5) [redacted] gave evidence that the van was equipped with a rear facing camera to aid reversing, but no front or rear facing audible impact sensor alarms. 6) [redacted] gave evidence that UPS drivers were subject to an annual appraisal that involved being accompanied by an assessor who would complete a 60 item tick box form, but that drivers were neither told if they had failed any part of that assessment or offered any refresher training following such an appraisal.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 16/09/2022. If requested to do so, I may extend that 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 Person: [redacted], son of the deceased (directly and to his solicitors). I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both of this report and your response 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	Dated 22/07/2022