**Newcastle upon Tyne Coroners**
**MISS GEORGINA NOLAN**
**HM ASSISTANT CORONER**
**Civic Centre , Barras Bridge , Newcastle Upon Tyne , NE1 8QH**
[redacted]

Date: 2 August 2022
Case: 306745

**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

**THIS REPORT IS BEING SENT TO:**

The Rt Hon Grant Shapps, Secretary of State for Transport

and

Baroness Vere of Norbiton, Parliamentary Under Secretary of State

**CORONER**

1 I am Georgina Nolan, Assistant Coroner for the coroner area of Newcastle and North Tyneside (Lower Ground Floor, Block 1, Civic Centre, Barras Bridge, Newcastle Upon Tyne, NE1 8QH).

**CORONER'S LEGAL POWERS**

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and
2 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

**INVESTIGATION and INQUEST**

On 1 July 2019 I commenced an investigation into the death of Stanley HARDY aged 83. The investigation concluded at the end of the inquest on 28 July 2022.

The conclusion of the inquest was Road Traffic Collision

3 1a Blunt Head Injury

1b

1c

II

4 **CIRCUMSTANCES OF THE DEATH**

On 16th June 2019 the deceased (a pedestrian) crossed into the carriageway of Peel Street, Sunderland against a red light. He was hit by a coach turning right into the junction from Toward Street. Although the coach driver saw the pedestrian in the road prior to the collision and applied his brakes, he did not do so forcefully, conscious of the welfare of the passengers travelling in his vehicle. The pedestrian was hit by the coach, thrown to the ground, and suffered serious head injuries from which he died the following day.

**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. –

[BRIEF SUMMARY OF MATTERS OF CONCERN]

5 (1) The coach driver's evidence was that although he saw the pedestrian in the carriageway he did not forcefully apply his brakes as he had been trained not to do so to protect the welfare of the passengers travelling in his vehicle.

(2) Evidence from the Forensic Collision Investigator was that:

i. If emergency braking had been applied the coach could have stopped prior to hitting the pedestrian or the collision would have occurred at a significantly reduced speed; and
ii. Emergency braking procedures do not form part of the required training for new bus and coach drivers.

**ACTION SHOULD BE TAKEN**

6 In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

**YOUR RESPONSE**

You are under a duty to respond to this report within 56 days of the date of this report,
7 namely by 27 September 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.

**COPIES and PUBLICATION**

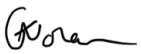
I have sent a copy of my report to the Family of the Deceased and Chief Coroner.

I am also under a duty to send the Chief Coroner a copy of your response.

8 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 2 August 2022



for Newcastle upon Tyne Coroners