REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Public Transport Department Local Authority for City of Kingston Upon Hull and Hackney Carriage Association for the area of Kingston Upon Hull
1	**CORONER** Miss Lorraine Harris, Area Coroner, East Riding of Yorkshire and City of Kingston Upon Hull.
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 2nd September 2021 I commenced an investigation into the death of Rebecca Lisa KIRBY, aged 31 years. The investigation concluded at the end of the inquest on 29th March 2023. The conclusion of the inquest was Road Traffic Incident. Box 3 of the record of inquest read: On the evening of 27th August 2021 Rebecca Lisa KIRBY was out socialising. She misjudged the traffic on Lowgate, Hull and ran in to the path of an oncoming vehicle. The vehicle was travelling at 23 miles per hour however the way Ms Kirby landed resulted in significant head injuries, causing her to become immediate unresponsive. Despite many people coming to her aid to offer advanced life support, she remained in cardiac arrest. She was transported to Hull Royal Infirmary where she was declared deceased. One of the findings of fact stated: Miss Kirby had crossed behind a passing car which would obscure any oncoming vehicles view of her. In addition to lights, taxis and other pedestrians in the vicinity. His medical cause of death was recorded as: **1a** Intracranial Haemorrhage

	1b Road Traffic Incident
4	**CIRCUMSTANCES OF THE DEATH** Miss Kirby was out socialising with friends. She had consumed alcohol and was in an area of Hull known for its night time economy. She became separated from her friends and after looking in one location crossed a road. She misjudged the crossing and despite seeing the vehicle still attempted to cross the road. When struck by the car she landed on her head causing catastrophic injuries. Police witnessed the incident and were immediately on scene. Throughout the advanced life support she remained in cardiac arrest, without a pulse or signs of breathing. She was conveyed to Hull Royal Infirmary where CPR was ceased and she was declared dead.
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) On a Friday and Saturday night the Lowgate area of Hull city is exceptionally busy with people enjoying the night time economy. As such many are in drink. The area of Lowgate is open to traffic, it is also the location of a taxi rank. There is only one crossing facility (aside from at either end of the road), the road narrows significantly at one end. (2) Police raised concerns as follows: - The road remaining open during a Friday and Saturday night. - The number of pedestrians using the area. - Many people in drink in the area having to cross the road. - The road is a 30 mph. - Lights of vehicles are distracting - The location of the taxi rank, pedestrians having to navigate around the parked taxis, some with lights on, to enter the road. Taxis do 3 point turns in the road and any vehicle doing this is a danger to pedestrians. (3) Evidence was heard one doorman working in the area who stated "Having worked at the same location for some time, the area where the bars are on Lowgate is an accident waiting to happen. Members of the public are leaving the bars in a drunken state and they just wander into the road to cross, many of them not even looking for traffic on the road. Some vehicles travel down Lowgate far too fast given the evening activity" and another doorman stated "the road and both the footpaths at the location of the collision occurred on Lowgate are both very

	narrow. There is also a taxi rank outside O'Leary's which doesn't help as taxis were parked there at the time of the collision. I have seen numerous near misses over the years I have worked in the area. It is no exaggeration to say that there are between six to twelve incidents each night between cars and pedestrians, one thing which does not help and is also dangerous are taxis which do U turns in the road once they have collected their fare". (4) The police had previously made recommendations and further felt that closing Lowgate to all through traffic on a Friday and Saturday evening, making Lowgate a total no stopping zone on an evening between certain hours, moving the location of a taxi rank onto nearby Alfred Gelder Street. (5) I note the statement from the local authority listed - They have erected 2 speed signs since the incident. Bearing in mind that this incident occurred with a vehicle travelling well within the limits, traffic is the concern not limited to the speed of vehicles. - The council was looking at developing a document that reviewed speed limits for the whole of the city centre. Lowgate has a special reason for being an area of concern and should be looked at as a priority and not in conjunction with all other city centre streets. - That engagement with the councils public transport department has commenced with the intention to relocate the taxi rank to Alfred Gelder street "but this requires consultation with the Hackney Carriage Association". No indication was given regarding what was being done to facilitate this. - The council say that there are no resources to manage the road closure, despite acknowledging it is their responsibility. The fact the road is open at this time is a danger and I am concerned given the comments of the doormen that the danger is being underestimated. - Crossing facilities had been looked at but could not be positioned within a suitable distance. (6) I am concerned that inappropriate weight has been given to the danger arising in this area and that without appropriate action further incidents will occur.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your department/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 24th May 2023. 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 • The family of Rebecca Lisa KIRBY • [redacted] (legal representative for driver) I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE]** **[SIGNED BY CORONER]** ***29th March 2023*** ***Lorraine Harris***