REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: , Head of Airside Operations, Heathrow Airport Ltd, The Compass Centre, Nelson Road, Hounslow, Middx. CORONER I am Richard Furniss, assistant coroner for the coroner area of West London 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. **INVESTIGATION and INQUEST** An investigation was commenced into the death of JOHN DAVID COLES (date of birth 19 March 1973) on 14 February 2018. The investigation concluded at the end of the inquest on 21 July 2023. The conclusion of the inquest was that the Deceased died of multiple injuries as a result of an Accident. CIRCUMSTANCES OF THE DEATH 4 Shortly before 0600 hours on 14 February 2018, the Deceased was driving a British Airways Renault Kangoo across and uncontrolled crossing of Taxiway C at Heathrow Terminal 5. The uncontrolled crossing ran between stands 546/547 and 556/557. Once he had entered that crossing he had to proceed and was not permitted to stop. About 20 metres from the end of the uncontrolled crossing (which was 105 metres in length) a Heathrow Airport Ltd ("HAL") HiLux vehicle travelling south along taxiway C at 40 mph or more struck his Kangoo on the passenger side, causing the Deceased fatal injuries. The HAL driver of the HiLux had not seen the Deceased's Kangoo on the crossing. The jury found (and I agree) that an influencing factor in the Hilux driver's failure to see the Kangoo was was background visual interference. 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) This fatal accident occurred well over 5 years ago. The expert report of which raised the issue of background visual interference as a possible causative factor, was produced well over 4 years ago. Nonetheless, prior to the inquest, no specific consideration appears to have been given to this phenomenon by HAL (or by the HSE or in the Jacobs report which HAL commissioned). (2) Indeed, in evidence, you seemed reluctant to accept that this might have been a factor (and may therefore be a factor in a future accident). Despite your Counsel's submissions, therefore, I believe it is necessary to highlight this hazard by way of this report and to obtain your (HAL's) response. (3) It is also the case that white-coloured vans driven by British Airways employees may be difficult to see. opinion was that there may be merit in using side profile lights on vehicles which may need to cross uncontrolled

crossings. While this may primarily be a matter for British Airways (and other

| | organisations), HAL has ultimate oversight and has the power at least to recommend consideration of side profile lights. |
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| 6 | ACTION SHOULD BE TAKEN |
| | In my opinion action should be taken to prevent future deaths and I believe you and other officers of HAL 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 18 September 2023. I, the coroner, may extend the period. |
| | Your response should 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 this report to the Chief Coroner and to the Solicitors acting for the Family of the Deceased, John David Coles. |
| | 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 | 24 July 2023 [SIGNED BY CORONER] |