

## **Regulation 28: REPORT TO PREVENT FUTURE DEATHS**

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

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	REGULATION 28 REPORT TO PREVENT DEATHS
	THIS REPORT IS BEING SENT TO:
	1 Secretary of State - Department for Transport
1	CORONER
	I am Robert SIMPSON, Assistant Coroner for the coroner area of Berkshire
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 09 November 2022 I commenced an investigation into the death of Terence Charles Scott DUNCAN aged 48. The investigation concluded at the end of the inquest on 16 November 2023. The conclusion of the inquest was that:
	On the 30th October 2022 Terence Charles Scott Duncan died on the A4 Bath Road, Slough having been run over by a lorry. He had deliberately started to pass under the skeleton-trailer in front of the trailer wheels in order to cross the road when the lorry moved off.
4	CIRCUMSTANCES OF THE DEATH
	On the 30 <sup>th</sup> October 2022 an articulated lorry was travelling through Slough on the A4. The traffic was very heavy due to a closure of the M4. The lorry trailer was an unloaded trailer designed to carry a shipping container.
	The lorry moved off from a set of traffic lights and its route was blocked for a few seconds by another vehicle. This caused the trailer to obstruct a pedestrian crossing.
	Mr Duncan was crossing the road and made the decision to duck under the skeleton of the trailer rather than walking around the vehicle. He had a clear view through the trailer unit when he did this. Sadly the lorry moved off before Mr Duncan reached the far side of the road and he was run over by the rear nearside tyres.
5	CORONER'S CONCERNS
	During the course of the investigation my inquiries 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 <b>MATTERS OF CONCERN</b> are as follows: (brief summary of matters of concern)
	I heard evidence regarding the requirement for sideguards or underrun protection devices to be installed on certain heavy goods vehicles. The Road Vehicles (Construction and Use) Regulations 1986 set out the legal requirements.
	I note that the official government website states that sideguards or lateral protection

	I have also sent it to <b>Thames Valley POLICE</b> who may find it useful or of interest. 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 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 by the Chief Coroner.
	<ul> <li>Thames Valley POLICE</li> <li>who may find it useful or of interest.</li> <li>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.</li> <li>I may also send a copy of your response to any person who I believe may find it useful or of interest.</li> <li>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</li> </ul>
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	Thames Valley POLICE who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all
	Thames Valley POLICE
	I have also sent it to
	(the mother of Mr Duncan)
	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons
8	COPIES and PUBLICATION
	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.
	You are under a duty to respond to this report within 56 days of the date of this report, namely by January 12, 2024. I, the coroner, may extend the period.
7	YOUR RESPONSE
	In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.
6	ACTION SHOULD BE TAKEN
	I am concerned that there is no lesser risk posed to pedestrians or cyclists by an extendable trailer than that posed by a fixed trailer of the same length which would have been required to have a more comprehensive sideguard device installed.
	The sideguard on this trailer was only 50cm long whereas the distance between the wheels of the cab unit and trailer wheels was 3 metres when extended. The trailer was extended despite being not being loaded with a shipping container at the time. There was therefore a very significant gap between the end of the sideguards and front of the following wheels.
	I was informed that the type of trailer involved in this inquest was an extendable trailer and therefore its construction was in compliance with the Regulations as long as the requirements were met when the trailer was in its shortest configuration.
	by a vehicle travelling in a forward direction.



hu & Robert SIMPSON Assistant Coroner for Berkshire