REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Walsall MBC**
1	**CORONER** I am Mrs Joanne Lees Area Coroner for the Black Country Jurisdcition.
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. https://www.legislation.gov.uk/ukpga/2009/25/schedule/5 https://www.legislation.gov.uk/uksi/2013/1629/part/7
3	**INVESTIGATION and INQUEST** On 22/12/23 I commenced an investigation into the death of Mr David WELLINGTON aged 54 years. The investigation concluded at the end of the inquest on 23/4/24. The medical cause for the death of Mr Wellington was; 1a Haemothorax 1b Fatal chest injuries 1c Road traffic accident The conclusion of the inquest was Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 10:34 hrs on Tuesday the 12th December 2023, a fatal road traffic collision occurred on a service road off Leamore Lane, Walsall. The collision occurred between a Renault box van and Mr David WELLINGTON who was a pedestrian. The van was reversing at the time of the collision. As a result of the collision sadly Mr David WELLINGTON died at the scene. Mr Wellington was a resident at a block of flats accessed via the service road on which the collision took place. The collision itself was captured in its entirety on nearby CCTV. A police investigation established that Mr Wellington (who was wearing a parker coat with the hood up) had entered the service road through a pedestrian barrier and was positioned in the blind spot of the reversing van and that Mr Wellington would not have been visible to the driver. It is not known whether Mr Wellington had seen the van reversing. The driver of the white van was using his hazard lights but the van did not have warning beeps when reversing as this was not a legal requirement for this size of van. The van was noted to

	be particularly quiet when reversing. It is not known why Mr Wellington. did not appear to hear the vehicle reversing.
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. I heard evidence at inquest that the service road provides access to the shops that face onto Leamore Lane for delivery purposes. The service road opening is off Bloxwich Road and has a barrier which is operated manually, being opened for deliveries normally by the shop keepers. I heard evidence that the service road is a single carriageway which is used by both vehicles AND pedestrians. As you enter the road, the road is lined with metal fencing on the left side of the road which has openings onto two pathways for access to the flats on Comwall Close (incorrectly referred to as Camwell Close in the Police report). 2. There is no designated pathway for pedestrians when using the service road for the purpose of accessing the nearby flats. Designated pedestrian access from Leamore Lane and Bloxwich Road via a pathway still requires a pedestrian to cross the service road itself. Pedestrian access is not sited on the same side as the flats. In my view this presents a risk of future deaths. 3. There are no road markings designating a pedestrian route nor any clear and designated pathway separating a pedestrian route to the flats from the service road itself. In my view this presents a risk of future deaths. 4. On the day of the collision, there were two large council bins intruding into the carriageway positioned just before the opening of the pathway. There were also two vehicles parked stationary at the side of the service road and a blue skip in the roadway. It was obvious from the evidence that the service road was being used for purposes other than which it was designed and that there were a number of obstructions present in the service road presenting a risk to pedestrians using the service road to access the flats and therefore reducing their visibility to vehicles using the service access road. In my view this presents a risk of future deaths. 5. The manual operation of the barrier coupled with the obstructions in the service road itself present a risk to the ability of emergency services (Fire & Ambulance) to access the service road and operate effectively within the service road area if needed. The police investigation noted that the skip and bins had to be moved out of the way on the day of the incident involving Mr Wellington to make room for the emergency services. In my view this presents a risk of future deaths. 6. There appear to be no signs alerting anyone using the access road to the potential presence of pedestrians within the service road area and no speed limit for vehicles using the service road. In my view this presents a risk of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **21/6/24**. 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 and to the The family of Mr Wellington. I have also sent it to the Forensic Collision Unit of West Midlands Police and West Midlands Ambulance Service 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 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	**25/4/24** JMLees **Mrs Joanne M. Lees** **HM Area Coroner** **The Black Country Jurisdiction**