Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Driver and Vehicle Standards Agency** **Berkeley House** **Croydon Street** **Bristol** **Somerset** **BS5 0DA**
1	**CORONER** I am Johanna THOMPSON, Area Coroner for the coroner area of Norfolk
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 04 September 2024, I commenced an investigation into the death of Alan Richard BAKER aged 67. The investigation concluded at the end of the inquest on 16 December 2025. **The medical cause of death was:** 1a) Traumatic Chest, Pelvis and Leg Injury 1b) Road Traffic Collision 1c) 1d) 2) Ischaemic Heart Disease, Systemic Hypertension, Type 2 Diabetes Mellitus **The conclusion of the inquest was:** Road Traffic Collision
4	**CIRCUMSTANCES OF THE DEATH** On 7th August 2024, Mr Baker was travelling on his motorcycle along Muck Lane, Rackheath when the LGV behind which he was travelling stopped to allow another vehicle to pass and carried out a reversing manoeuvre. Due to the close proximity of the motorcycle to the LGV it ran over Mr Baker causing him to sustain catastrophic injuries. He was taken to Norfolk and Norwich University Hospital, Colney Lane, Norwich, where he sadly died as a consequence of his injuries on 25th August 2024.
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 **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern)

	I have concerns that (a) there is no mandatory requirement for LGVs to have reversing cameras fitted to enable drivers to see more thoroughly behind their vehicle before carrying out a reversing manoeuvre and (b) that there is no mandatory requirement for the owners of vehicles which do have such cameras to ensure they are maintained in a fully functioning state.
6	**ACTION SHOULD BE TAKEN** 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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by February 17, 2026. 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 following Interested Persons Mrs Baker's Next of Kin Solicitor for TP Driver Norfolk Constabulary I have also sent it to Department of Transport 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.
9	**Dated: 24/12/2025** [redacted] **Johanna THOMPSON** **Area Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH


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