

# LEARNING FROM TRAGEDY

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## CORONIAL INQUESTS AND PREVENTION OF FUTURE DEATH REPORTS FOR ROAD FATALITIES IN THE UK

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The PACTS logo features a cluster of blue and green dots of varying sizes, arranged in a roughly circular pattern to the right of the text.

## Acknowledgements

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## About PACTS

The Parliamentary Advisory Council for Transport Safety (PACTS) was formed in 1982 by parliamentarians and experts from a range of disciplines who had amended what became the Transport Act 1981 which made seat belt wearing compulsory in Great Britain.

Our vision is for a transport system free from death and life-changing injury, in which all users feel safe.

PACTS is the only NGO which combines all the following:

- addresses transport safety (road, rail and air) across the UK;
- focuses on parliament, Government and stakeholders;
- has a wide membership base across the modes and the public, private and third sectors;
- believes strongly in evidence-based policy;
- has no commercial or sectional interests.

It provides the secretariat to the All-Party Parliamentary Group for Transport Safety.

PACTS has over 130 member organisations from across the modes and the public, private and third sectors. We welcome new members. Further details about PACTS can found at <http://www.pacts.org.uk>

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# Learning from Tragedy

*Coronial Inquests and Prevention of Future Death Reports for Road Fatalities in the UK*

Nick Reed & Jeremy Phillips

## Executive Summary

This report outlines the roles of coroners and the Prevention of Future Death (PFD) reports in raising matters of concern in the interests of enhancing public safety and how this process may be improved.

## Coronial Inquests and PFD Reports

Coronial inquests investigate violent or unnatural deaths to determine how fatalities occurred, without assigning blame. PFD reports, mandated by the Coroners and Justice Act 2009, are issued when an inquest identifies concerns that, in the opinion of the coroner, could prevent future deaths if they were adequately addressed. These reports, sent to relevant authorities or organisations, must receive a response within 56 days detailing actions either taken or planned to address the concerns (or an explanation as to why no action has, or will be, carried out). However, there is no requirement for coroners to follow up on these responses and no sanctions for those who fail to respond or act upon receipt of a PFD report.

## Enhancing Road Safety through PFD Reports

PFD reports could play a proactive role in road safety by holding individuals, organisations and authorities accountable for addressing identified matters of concern. Furthermore, there is the potential in future that the analysis of trends from multiple reports could enable policymakers to make informed decisions on road safety regulations, infrastructure development, and public awareness campaigns. Examples include modifying road layouts, implementing new traffic signs, and enhancing vehicle safety features. However, there is latent potential for further improvements to road safety through deeper consideration of crash causation from a Safe System perspective.

## Enhancing the post-fatal crash response

This report explores how dedicated investigation branches in the aviation, marine, and rail sectors enable more thorough investigations of road crashes, identification of systemic issues, liaison with stakeholders and tracking the implementation of safety measures. The relationship between functions that could be performed by an investigation branch for road crashes, coroners' inquests and PFD reports – and the extent to which they can form a mutually supportive process – are addressed in the report.

## Conclusion and Recommendations

The report concludes that, when PFD reports are issued, they can be effective at galvanizing action to prevent future fatalities. However, PFD reports have been produced for less than 3% of road fatalities since 2013, highlighting a need for improved analysis of road crashes and better tracking and enforcement of the measures proposed to reduce risk. Recommendations include training coroners in Safe System principles, routine involvement of Safe System experts in inquests, revisiting how the functions performed by investigation branches in other modes can be delivered for road transport, and enhancing the capture and dissemination of lessons learned from fatal crashes.

The report outlines how more can and should be done to capture the learning from fatal crashes, helping to bring peace to those who have lost loved ones and preventing others suffering the same fate.

## About the authors

### *Nick Reed, Founder, Reed Mobility*

For more than twenty years, Dr Nick Reed has worked consistently at the cutting edge of road safety research. In 2019, he founded Reed Mobility – an independent expert consultancy on future mobility working across public, private and academic sectors to deliver transport systems that are safe, clean, efficient, ethical and equitable. In November 2021, he was appointed as the first ever Chief Road Safety Adviser to National Highways, providing review and challenge to the organisation in its aim to deliver Vision Zero on the national strategic road network. Nick is also a trustee of the charities Brake, RoadSafe and the Road Safety Trust.

### *Jeremy Phillips, Independent*

Jeremy is an independent road safety expert who has spent over thirty years working in the field as a researcher, practitioner, operations manager, partnership manager, team leader and latterly as Head of Road User Safety at National Highways. Jeremy has been a long-standing advocate of evidence-based practice and developing the role of analysts working in road safety, most especially during his time as Director of Research for Road Safety Great Britain. He has also established road collision investigation systems and capability at local highway authority level, including a regional professional support function for those involved in collision investigation. He is a committed advocate of a Safe Systems approach to road injury reduction and has commissioned projects to support operational, rather than theoretical, approaches to the System.

## Introduction

Aside from the years affected by the COVID-19 pandemic, the numbers of people dying or suffering serious injury on British roads each year have been sadly consistent over the last decade. Against a backdrop of increasing traffic, the relative rates of serious crashes have been gradually reducing. However, this is of little comfort to the tens of thousands of people affected by such crashes or to the friends and families who have lost loved ones in road incidents. A common response to the sudden and traumatic loss of a loved one in a road collision is to seek ways to prevent others from experiencing the pain and suffering caused by such events.

The aspiration to learn from crashes is captured in the Safe System approach to road safety (see Appendix A). Importantly, the Safe System starts from the principle that death or serious injury for any road user cannot be considered an acceptable outcome from the use of motor vehicles on public roads. The Safe System framework for seeking ways to reduce the risk of death and serious injury typically has five categories, one of which is 'Post crash response' (see Figure 1).

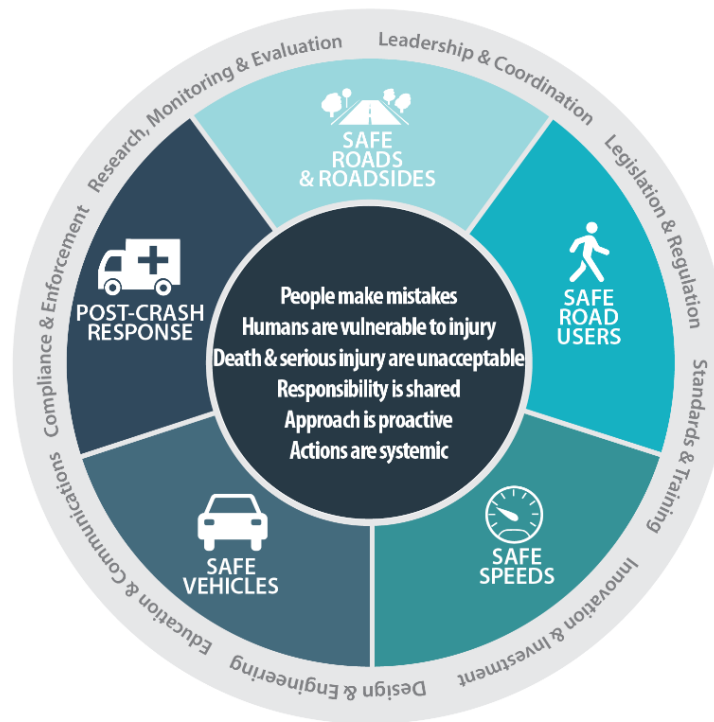


Figure 1. Safe System framework. Source Agilysis, 2022 (based on models by Commonwealth of Australia, 2022; PACTS & Loughborough Uni, 2017; NZ Transport Agency, 2016; Canadian Council of Motor Transport Administration, 2016).

The occurrence of a crash that results in serious or fatal injury means that the system has failed to provide the necessary protections to prevent it. However, an effective post-crash response capability means rapid action can reduce the extent of fatal and serious injuries experienced. In the longer-term, there is the opportunity to learn why collisions occur and what mitigations could help to prevent similar crashes in future.



This learning can be of great reassurance to crash victims or grieving friends and family; to feel that no-one else need experience the same loss they have for the same reasons. Guidance notes from the UK Chief Coroner reflect this aim of the Safe System, stating that a bereaved family should be able to say that while a “...death was tragic and terrible, at least it shouldn’t happen to somebody else.”<sup>1</sup>.

This report explores mechanisms to facilitate the process of learning from fatal road crashes and potential ways to improve this process.

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<sup>1</sup> Chief Coroner Guidance No. 5 Reports to Prevent Future Deaths (2016) <https://www.judiciary.uk/wp-content/uploads/2013/09/guidance-no-5-reports-to-prevent-future-deaths.pdf>

## Coronial inquests

An inquest is an investigation into a violent or unnatural fatality carried out to discover the identity of the deceased and where, when and how their death occurred. Coroners are responsible for making enquiries where the cause is unknown and investigations are made on their behalf by a coroner's officer. The inquest produces no formal allegations or accusations and has no power to blame anyone directly for the death. At the end of the Inquest, the coroner records findings and provides a conclusion about the death. This will appear on the death certificate of the deceased and the death can be officially registered.

A coronial inquest will be conducted for road fatalities when no criminal prosecution occurs. If someone is likely to face criminal charges for causing the death, the coroner will usually suspend their investigation until the criminal proceedings have finished. Thereafter, the coroner can only resume the investigation if they consider that there is a "sufficient reason" for doing so. Two thirds of fatal road crashes result in an inquest. Inquests can be held after a criminal trial but this is uncommon. Inquests relating to road deaths are only a small proportion of the number of deaths that are subject to coronial scrutiny, accounting for around 2% of the total number of inquests undertaken by coroners<sup>2</sup>.

### Prevention of Future Death reports

If an inquest identifies matters of concern that could prevent future deaths, there is a duty to issue a **Prevention of Future Death (PFD) report**, as defined in the Coroners and Justice Act 2009 (paragraph 7, Schedule 5). Such a report is produced on a standard template<sup>3</sup> and identifies features of incidents that, if addressed, could help to reduce the likelihood of future fatalities of a similar nature. These are identified by the coroner as 'matters of concern'. The intent of a PFD report is to improve public health, welfare and safety and not to attribute blame for factors that have contributed to fatalities.

The report is sent to the relevant individuals, authorities or organisations that, in the opinion of the coroner, have the power to act (or who have the authority to instruct others to act) to prevent future deaths. Recipients have a legal duty to respond to a PFD report in writing within 56 days

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<sup>2</sup> RoadPeace – Effective Inquests <https://www.roadpeace.org/working-for-change/effective-inquests/>

<sup>3</sup> Regulation 28 Report template (2020) <https://www.judiciary.uk/wp-content/uploads/2020/11/GUIDANCE-No.5-ANNEX-A-TEMPLATES.pdf>

and a coroner can extend this period upon request. Respondents must provide details of action taken or proposed to be taken with a timetable to address the concerns raised or otherwise explain why no action has been taken or proposed.

The guidance to coroners states the decision to produce a PFD report should consider whether changes already planned or implemented by an organisation have made such a report superfluous. However, a coroner may choose to continue with the report if the cause for concern could highlight a broader issue beyond the specific concern addressed in relation to the fatality under review.

When a PFD report is produced, there is no guidance that suggests or requires coroners to follow up on stakeholders' responses or completion of proposed actions. With no official sanction, there may be no incentive to address coroners' matters of concern – perhaps until such time as it becomes clear to the authority or organisation that other incidents have subsequently occurred that share the same collision and/or injury characteristics as those for the fatality within the PFD report. An organisation or individual that had failed to address the cause of an incident raised as a matter of concern in a PFD report would be in a very difficult position in the event of a legal challenge and media coverage would potentially be disparaging.

The Health and Safety at Work Act<sup>4</sup> places a duty on employers and self-employed persons to ensure that employees and non-employees are, so far as is reasonably practicable, not exposed to risks to their health and safety. Since matters of concern identified by a coroner recognise potential risks that might be addressed by the recipient(s) of the report, health and safety legislation presents a potential route to sanctioning the failure to act by PFD report recipients.

### Process of Producing a PFD Report

1. **Evidence Analysis:** During the inquest, evidence is presented that might raise concerns about potential future incidents. This could include:

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<sup>4</sup> Health and Safety at Work etc. Act 1974. <https://www.legislation.gov.uk/ukpga/1974/37/contents>

- Driver behaviour
- History of incidents on a specific road section.
- Issues with road design or signage.
- Shortcomings in vehicle safety features.

This evidence is likely to be derived from police investigations using the STATS19 incident data collection protocol.

2. **Report Issuance:** If the coroner believes action can prevent future deaths, they issue a PFD report outlining the matters of concern.

- The report specifies the recipient, such as the Department for Transport or relevant highway authorities responsible for the identified risk area.

3. **Response and Follow-up:**

- The recipient has a legal duty to respond in writing within 56 days, detailing actions taken or planned to address the recommendations or providing an explanation as to why no action can or will be taken.
- The coroner can request clarification or grant extensions if needed.

PFD reports enable coroners to play a positive role in improving road safety. Firstly, through the matters of concern identified in relation to the fatality. Secondly, by each PFD report contributing investigative insights to a potentially powerful national resource available for analysis by a range of actors working towards reducing road fatalities. These reports hold relevant authorities accountable for addressing identified risks and potentially saving lives on the roads.

- **Identifying Trends:** By analysing multiple PFD reports, authorities can identify common factors contributing to road fatalities, such as dangerous road layouts, inadequate signage or incorrect navigation system guidance, etc.

- **Informing Policy:** Insights from PFD reports can inform policymakers about necessary changes in road safety regulations, like updating speed limits, mandating safety features in vehicles or in the further development of innovations such as connected and automated vehicles or electric vehicles.
- **Operational decision making:** Insights from PFD reports may help to inform decision making in organisations about resource prioritisation, resource allocation, service provision and asset deployment.
- **Guiding Infrastructure Development:** PFD reports can highlight areas where road infrastructure improvements are needed, prompting road authorities to prioritise certain projects.
- **Enhancing Public Awareness:** Sharing the findings from PFD reports with the public can raise awareness about road safety issues and encourage safer behaviours.
- **Supporting Research:** Researchers can use data from PFD reports to study road safety issues in depth, leading to innovative solutions and safety measures.
- **Legal and Regulatory Changes:** Recommendations from PFD reports can lead to changes in laws and regulations governing road use, vehicle standards, and driver education.
- **Training and Education:** The reports can be used to develop training programs for drivers, especially in professional settings, to reduce the risk of accidents.

Acting on the concerns raised in PFD reports, authorities and organisations can make targeted interventions to enhance road safety and save lives. Two examples of fatal road incidents that resulted in PFD reports are presented in Appendix B.

### Example actions following a PFD report

- **Infrastructure Improvements:** Following a report highlighting dangerous road design or signage issues, authorities might:
  - Undertake a review.
  - Implement new traffic lights, signs, or road markings.
  - Modify road layouts (e.g., adding roundabouts, widening lanes).

- Improve road surface conditions or visibility.
- **Vehicle Safety Measures:** A report concerning a specific vehicle safety concern could lead to:
  - Recalls or modifications of specific vehicle models.
  - Manufacturers implementing new safety features in future models.
  - Increased government pressure on car manufacturers to prioritise specific safety features.
- **Driver Education and Awareness Campaigns:** Reports highlighting risky driver behaviour could result in:
  - Targeted campaigns educating drivers on the dangers of those behaviours (e.g., speeding, drink-driving, using mobile phones).
  - Changes to driver training curricula to emphasise specific safety aspects.
- **Enforcement**
  - Matters of concern identified in PFD reports might help to steer police enforcement strategies, operational plans and national policies and guidance.

### Preventable Deaths Tracker

In 2020, Dr Georgia Richards at the University of Oxford was funded by the National Institute for Health and Care Research (NIHR) School for Primary Care Research to launch a web-based tool to track and share the production and responses to PFD reports. This website is known as the Preventable Deaths Tracker<sup>5</sup> and holds over 5,000 reports, dating from when they were first made publicly available in 2013. Of these, just over 350 relate to road fatalities. Run in cooperation with the Chief Coroner, the tracker is an excellent resource for tracking the publication of and follow up to PFD reports but is run on limited resources in an unofficial capacity. Published research using the tracker has to date focused on

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<sup>5</sup> Preventable Deaths Tracker website: <https://preventabledeathstracker.net/>

deaths related to medicines but was used for a 2021 study of PFD reports relating to cyclist fatalities<sup>6</sup>, highlighting its potential wider application in road transport. An ongoing national resource based on, or using, this model could be hugely valuable.

### Frequency of PFD production following road deaths

Independent research received by PACTS<sup>7</sup> identified that for 16,986 road deaths in the years 2013-2023, there were 388 PFD reports. That is a return of PFD reports from 2.3% of road fatalities or 1 report for every 44 road deaths. There is also considerable regional variation in PFD production over the same period – some coroner areas produced PFD reports for more than 5% of road deaths (e.g. Newcastle and North Tyneside: 6 PFD reports for 66 road deaths; Manchester South: 9 PFD reports for 148 road deaths) whereas some coroners produced none (e.g. Buckinghamshire: 0 PFD reports for 195 road deaths; Manchester City: 0 PFD reports for 127 road deaths). Given the potential to learn from each and every collision and to determine potential mitigations that could prevent such incidents in future, these overall percentages seem to be a very low.

The absence of a PFD report may cause grieving families to feel that the circumstances that led to their personal tragedy may arise again, leading to further fatalities and suffering for victims' friends and relatives. However, the failure to produce a PFD report does not necessarily mean that the opportunity to learn from a fatal crash has been missed. There are a number of variables that will affect the percentage of road deaths subject to a PFD report letter. Some absences are fully justified, for example where authorities support the inquest in a manner that satisfies the coroner that such a report is not required, even if specific actions to address collision risks remain outstanding. However, it does not seem plausible that this would account for the very low percentage of deaths that result in PFD reports. We can look at how learning from fatal crashes is captured and implemented in other transport modes to understand how this process could be enhanced following a road death to reduce the likelihood of future tragedies.

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<sup>6</sup> Odgers, Aronson & Richards (2021) Preventable deaths involving cyclists in England and Wales: Solutions to improve their safety. <https://www.gchu.org.uk/wp-content/uploads/2021/09/GCHU-Report-Preventable-Deaths-involving-Cycling-in-England-and-Wales.pdf>

<sup>7</sup> Taylor & Taylor (2024) TCS0017 Written evidence submitted to Justice Committee inquiry – The Coroner Service: follow-up. <https://committees.parliament.uk/writtenevidence/127537/pdf/>

## How it works in other areas of transport: AAIB

In the aviation, maritime and rail sectors, the process of learning from tragic incidents is supported by accident investigation branches. The Air-, Marine- and Rail Accident(s) Investigation Branches (AAIB, MAIB and RAIB) signed a joint memorandum of understanding with the Chief Coroner in 2017. This helps to define how coroners and the investigation branches can cooperate on delivering their respective roles and responsibilities under law<sup>8</sup>.

### AAIB investigations

The AAIB has been investigating fatal air crashes since 1915 (just twelve years after the Wright Brothers first flight at Kitty Hawk, North Carolina). The AAIB sends teams of inspectors to accident sites 30 to 40 times per year. Investigating such crashes is a meticulous process involving several key steps to determine the causes and contributing factors. Upon arrival, the team secures the area to preserve the scene and begins collecting critical information, including examining the wreckage and recovering the flight data recorder and cockpit voice recorder. They also gather witness statements and conduct interviews with first responders and relevant personnel.

The team analyses the flight data and voice recordings to understand the aircraft's performance and the crew's actions before the crash. Investigators conduct detailed examinations of the aircraft components to identify any mechanical issues and analyse human factors, such as the flight crew's training, experience, and possible fatigue. Additionally, they review operational aspects like air traffic control communications and weather conditions.

Within a few weeks, the AAIB issues a preliminary report that provides an overview of the investigation's progress and findings. If immediate safety issues are identified, the AAIB can issue urgent safety recommendations. The investigation then continues with more detailed analysis, including simulations and consultations with manufacturers and other experts. During these consultations, matters of concern that could be

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<sup>8</sup> Memorandum of Understanding between AIBs and Chief Coroner (2017) <https://www.gov.uk/government/publications/memorandum-of-understanding-between-the-aibs-and-the-chief-coroner/memorandum-of-understanding-between-aibs-and-chief-coroner>



logged in a PFD report by a coroner can be addressed by stakeholders, thereby helping to prevent future deaths and potentially satisfying a coroner that there is no need for a PFD report.

Ultimately, the AAIB compiles a final report that details the investigation's findings, conclusions, and safety recommendations. This comprehensive report is published and made available to the public, the aviation industry, and regulatory bodies. Following the publication, the AAIB monitors the implementation of its safety recommendations to enhance aviation safety and prevent future accidents. This comprehensive process ensures that potential contributory factors are considered and addressed, aiming to uncover the causes of the accident and improve aviation safety<sup>9</sup>.

### Issuing a PFD report

A coroner may issue a Prevention of Future Deaths (PFD) report following an AAIB investigation to address complementary aspects of the incident. While the AAIB focuses on the technical and operational causes of the aviation accident, the coroner examines the legal and medical circumstances of individual deaths. The coroner's PFD report might identify additional issues, such as systemic problems in emergency response or medical treatment, that were not the primary focus of the AAIB's investigation. The PFD report can complement the AAIB's safety recommendations by addressing broader preventive measures and ensuring wider dissemination of findings to stakeholders, including health services and local authorities. This process promotes public accountability and a coordinated approach to safety improvements, aiming for a comprehensive implementation of measures to prevent similar fatalities in the future.

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<sup>9</sup> It should be noted that road transport is a more open system compared to aviation. On the roads, close interactions between vehicles of different sizes and with other road users (cyclists, pedestrians etc.) are commonplace and involve drivers with a range of experience levels, capabilities and motivations. Aviation is characterised by greater regulation of airspace, aircraft and activity, with pilots required to maintain a level of training and certification that is absent in road transport.

## Capturing the learning from road deaths

It is apparent that an investigation branch for road collisions is absent from the list of those active in other transport modes. The sheer number and geographic spread of road fatalities means that an equivalent body for road transport would have to be either resourced to a level far greater than those operating in other transport modes or would have to approach their investigations of road crashes at a higher, thematic level.

The UK Government came close to pursuing this latter option with considerable work on the Road Collision Investigation Project, led by the RAC Foundation on behalf of the Department for Transport and National Highways leading to the development of a business case for a 'Road Safety Investigation Branch' (RSIB). However, these plans were rescoped with the focus narrowed from the broad topic of general road safety to the much narrower field of incidents involving automated vehicles<sup>10</sup>. The absence of RSIB means several features of the work of the other investigation branches is missing for road crashes:

- **Investigation of the circumstances and causes of road crashes is less comprehensive**
  - A coroner will use police reports associated with an incident. A police collision investigation may focus on apportioning blame for potential misdemeanours associated with the driver(s) and vehicle(s) involved in a crash rather than establishing key safety learnings from the incident.
  - This may miss some of the broader, systemic issues that contributed to the collision, such as characteristics of the road environment or the driving for work policies of the employer of a driver involved in a crash.
  - Whilst local highway authorities have a duty to undertake their own investigations into the causes of road collisions, unlike the police there is (a) no single accepted approach to these investigations, (b) investigations into single incidents may be absent in

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<sup>10</sup> The Automated Vehicles Act 2024, which received Royal Assent in May 2024, brought forward the concept of 'authorised automated vehicle incident inspectors', whose purpose is that of 'identifying, improving understanding of, and reducing the risks of harm arising from the use of authorised automated vehicles on roads in Great Britain.'. At the time of writing, no automated vehicles have been authorised for use on roads in Great Britain. The secondary legislation to support commercial deployment of automated vehicles is not anticipated to be completed until 2026 and the rollout thereafter is likely to be gradual. Whilst this work is absolutely required in evaluating the safety performance of this new technology working in a public environment, it is unlikely that the work of automated vehicle incident inspectors will make any significant impact on the overall road safety picture for many years to come.

favour of more general collision data analyses and (c) no automatic pathway exists for a local highway authority investigation to reach the inquest process.

- Dedicated collision investigators may provide this additional context and enhance understanding of why a crash occurred and how it may be prevented in future.

- **Liaison with stakeholders**

- As the circumstances surrounding a collision are revealed, an investigation branch can liaise with stakeholders to verify that they have understood correctly how the collision proceeded and whether there are particular actions that could prevent future crashes.
- Any such findings can be communicated with other related stakeholders so they can also take preventative action.

- **Aggregating and analysing crash causation factors**

- Over time, an investigation branch can build up records of the causative features of road crashes and identify emerging trends that indicate systemic issues. For example, seatbelt non-compliance might emerge as a specific issue for particular demographic group and / or in a particular location<sup>11</sup>. This trend may be missed if collisions are analysed individually but may become apparent if crash features are tracked over time.
- Identifying such trends could lead to more effective targeting of measures to prevent future deaths<sup>12</sup>.

- **Tracking actions**

- Since 2013, PFD reports have been published and, from 2023, there was a requirement to publish reports as webpages such that they were directly searchable. Recipients of PFD reports have a legal obligation to respond within 56 days – either to explain their planned or delivered actions to address the coroners' matters of concern or to explain why no action may be possible or necessary.

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<sup>11</sup> In the West Midlands, seatbelt non-compliance was observed to be seven times worse amongst the young, South Asian community. This prompted a targeted behavioural change campaign undertaken by SoMoCo – see <https://somoco.co.uk/ourwork/fastenup>

<sup>12</sup> Stanton, N. A. (2022) Road Collision Investigation Project Development of taxonomies and meta-analysis. RAC Foundation report. [https://www.racfoundation.org/wp-content/uploads/Stanton-2022-Road-Collision-Investigation-Project\\_Development-of-taxonomies-and-meta-analysis.pdf](https://www.racfoundation.org/wp-content/uploads/Stanton-2022-Road-Collision-Investigation-Project_Development-of-taxonomies-and-meta-analysis.pdf)

- However, even when responses are received there is no mechanism to oversee those responses. The Chief Coroner’s report for 2023<sup>13</sup> notes that:
  - *“The position in law is that once a PFD report has been issued, the coroner is ‘functus officio’ and has no legal power to take any further steps (other than determining any application by the report’s recipient for an extension of time in which to respond). That is as it should be, for coroners are judges, not regulators. However, the lack of an enforcement mechanism means that PFD responses are not always provided.”*
- The effectiveness of PFD reports could be enhanced by monitoring the matters of concern identified by coroners and then to track the stakeholders identified noting their willingness and ability to address them and the delivery and effectiveness of any subsequent actions proposed to address them.

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<sup>13</sup> Chief Coroner (2024) Report of the Chief Coroner to the Lord Chancellor. Annual Report for 2023.  
<https://assets.publishing.service.gov.uk/media/664c5701f34f9b5a56adcb16/chief-coroner-annual-report-2023.pdf>

## Conclusion and recommendations

Whether in transport or any other walk of life, understanding the causes of unexpected deaths and the measures that can be taken to prevent them are critical in helping the grieving friends and family of the deceased gain comfort from the knowledge that such deaths may be avoided in future.

Vision Zero, the aim to eliminate death and serious injury, is a commonly adopted approach to addressing safety risk in transport and other sectors. Indeed, it is widely acknowledged that this is the only ethically acceptable position that can be taken by organisations responsible for transportation. However, until zero deaths can be achieved (indeed, if that can ever be possible in the widely used, infinitely variable road environment upon which so much of our society depends), it will be vital that we learn from each tragic incident that occurs and implement countermeasures that could prevent such incidents from happening in future.

Police investigations, coroners' inquests and court cases help us to understand why serious crashes take place. PFD reports build on this understanding for stakeholders to consider taking actions to address the concerns that contribute to fatal crash risk. However, PFD reports have been produced for less than 3% of road fatalities since 2013 and, whilst there is a legal obligation to for stakeholders to respond to the matters of concern raised in PFD reports, tracking and enforcement of responses is limited. This process can be strengthened.

However, the important outcome following a fatal crash is the lessons learned and their application to prevent future incidents. A PFD report is a formal mechanism that captures aspects of this process but it can be improved. With PFD reports openly published, stakeholders may prefer not to be recorded as being associated with any matters of concern attributed to fatal incidents. Consequently, stakeholders will often seek to address any matter of concern before they are publicly referenced in a PFD report. If stakeholders have addressed matters of concern associated with a fatality, the need for a PFD report may be eliminated.

This is a good outcome in terms of learning from the specific incident and applying suitable countermeasures. However, the absence of published material highlighting coroners' matters of concern may mean that other related stakeholders do not benefit from this learning. A mechanism is required to capture and share the causes of fatal crashes, the actions taken to address them (and by whom) and the effectiveness of the

delivered countermeasures in reducing road risk. This information is captured for other transport modes in the form of their respective accident investigation branches but no equivalent body exists to deliver these functions for road crashes.

Five recommendations are described below that could improve how we learn from fatal road incidents.

- [Training for coroners in the Safe System](#)

Coroners have deep expertise in understanding the causes of deaths. Their access to deep expertise in road safety and crash causation is provided by police collision investigators. This is highly valuable but is delivered from a criminal justice perspective without necessarily reflecting all the facets of the Safe System approach to road safety. As noted, road deaths only account for around 2% of the total number of inquests undertaken by coroners and, of more than 5,000 PFD reports produced over the last ten years, only around 350 relate to road crashes.

However, there are very few serious road crashes that could be considered unpreventable and fewer still where a fatality would be the inevitable level of severity. This is the foundation of the Safe System approach to road safety. It is recommended that coroners receive training in the application of Safe System principles to the investigation of road collisions to gain a broader perspective on the potential matters of concern that they may wish to assign and greater awareness of the recipients who have the remit to address the concerns that the coroner believes will prevent future deaths.

- [Learning from the experience and processes applied in other transport sectors](#)

There are numerous reasons why learning from fatal road crashes may be enhanced by the work, building on the support that is provided by similar organisations operating in the air, rail and marine sectors.

*(a) Support for investigations*

In the aviation, rail and marine sectors, coroners can be supported by deep expertise within the accident investigation branches of the respective modes. Even if it were not possible to undertake in depth investigations for every fatal crash, more serious incidents could be prioritised with a focus on those where more detailed examinations would prove more decisive in improving understanding of crash causation. Further work could

also help to harmonise investigations nationwide to ensure that even when a more detailed investigation is not possible, those conducting any investigations are guided in delivering a comprehensive and consistent analysis.

*(b) Build relationships with key stakeholders*

The investigation branches build critical relationships with key stakeholders from across their respective industries, helping them to complete their investigations to the requisite level of detail but also enabling stakeholders to address coroners' potential matters of concern before a PFD report is produced. This speeds up the process of mitigating the identified risks but also saves stakeholders from the potential negative exposure of being identified as having some involvement pertaining to a serious incident. The critical learning from the incident can be retained by the investigation branch and shared with all stakeholders who may benefit from it.

*(c) Capture thematic collision features*

Road fatalities are geographically and temporally distributed – they happen in a variety of places and times. The police recorded STATS19 dataset captures some of the factor associated with crashes but, in the absence of thematic analysis of the reasons why fatal crashes happen, it is easy for commonalities between these crashes and the actions taken to prevent future similar deaths to be lost. In theory, stakeholders involved in the road transport sector (roads authorities, vehicle manufacturers, navigation system providers etc.) could do this for themselves by analysing PFD reports but this would be a time and labour-intensive process and, as noted, PFD reports are only produced for a small proportion of road deaths.

The accident investigation branches in other transport modes collate crash information to identify trends and help stakeholders to prioritise the actions that are likely to have the greatest impact in reducing the risk of death and serious injury. They can also track the actions taken to address coroners' matters of concern such that other stakeholders can adapt existing best practices to their own situation rather than having to invent solutions from scratch. This enables stakeholders to respond more swiftly and more efficiently (and potentially pre-emptively) to reduce road risk.

- Consistency of PFD reporting

Guidance for coroners highlights that PFD reports can be an important part of the post-crash experience for grieving family and friends to feel that others will not suffer the same emotional turmoil that they have endured. Similarly, coroners, collision investigators, emergency responders and other road users can experience significant trauma from observing repeated incidents in similar circumstances at a known collision hotspot. Very few fatal road crashes are unpreventable. Stronger guidance for coroners over the requirement to produce PFD reports may help to bring closure for grieving families and ensure that there is learning that may prevent future deaths.

- Strengthening responses to PFD reports

There is a legal duty for recipients to respond to the matters of concern identified in PFD reports:

- to set out the actions they will undertake to resolve the concerns;
- to request a delay to give more time to provide a response
- to explain why they believe no action is necessary.

However, there is no mechanism to enforce this duty. This means that recipients may neglect to address coroners' matters of concern (for a variety of reasons) with no material consequence. Failing to act means that the risk of future preventable deaths remains and families hoping to see outcomes that would reduce the likelihood of such deaths would not find the closure that they seek. Implementing rules that provide sanctions for those failing to address coroners' matters of concern (or failing to justify why no action is taken) may improve the response rate. As noted, the Health and Safety at Work etc Act 1974 may provide a route to this.

- Tracking recipients of PFD reports and completion of actions

The Preventable Deaths Tracker website has achieved a huge amount in capturing and sharing publicly available information regarding PFD reports. This could go further. For example, more could be done to track:



- Common matters of concern identified by coroners
- Common recipients of PFD reports.
- Common responses made by PFD report recipients
- Completion of actions by PFD report recipients
- Effectiveness of those actions in reducing road risk

Findings of such analyses could be shared with the Health and Safety Executive (HSE) to identify organisations that are failing in their duties of occupational health and safety to support safe road travel. Further, organisations that campaign for road safety could play a role in publicising the completion of actions by PFD report recipients and failures either to respond, to request a delay, to complete the required actions or notify the coroner why no action is required.

Road fatalities are relatively infrequent given the sheer volume of driving undertaken every day in the UK (approximately 5 deaths / per billion miles travelled each day). This appears to have engendered a societal indifference to road death and, despite decades of improvement in the numbers dying on our roads each year since the 1960s, the last ten years have been characterised by stagnation of this figure.

This level of risk does not appear to be accepted in any other transport mode. The process of learning from each death is a critical aspect of how we will continue to reduce the numbers suffering death and serious injuries on our roads each year and prevent the suffering of crash victims and their friends and relatives. PFD reports are an important and powerful element of this learning. However, their production can be improved and more can be done to ensure that recipients of PFD reports acknowledge their receipt and develop and implement suitable actions in response.

Beyond this, perhaps the key finding of this report is that the process of learning from road crashes is far from comprehensive. Other transport modes benefit from dedicated investigation branches that help to investigate serious incidents, to liaise with stakeholders and to coordinate and share the learning from such incidents. The process of implementing measures to address matters of concern identified in PFD reports can be strengthened but we can also improve how we learn from tragic incidents from the moment their causes are being investigated. The recommendations in this report outline how more can and should be done to capture this learning, helping to bring peace to those who have lost loved ones and improving the likelihood that no others will suffer the same fate.

## Appendix A: The Safe System

In the past, road crashes were typically seen as being an unfortunate but unavoidable consequence of the way we have developed our road transport system. Blame for such incidents was either shouldered by the driver(s) involved in any crash or that there was no-one to blame, with collisions simply seen as ‘accidents’; situations that happened unexpectedly and unintentionally but resulted in damage, injury or both.

In the 1990s, Sweden adopted an alternative approach called ‘Safe Systems’ (or the ‘Safe System’). This starts by taking an ethical position; that death or serious injury for any road user cannot be considered an acceptable outcome from the use of motor vehicles on public roads. It could be implied from this that there is the expectation of perfection in driving behaviour, infrastructure performance and vehicle design. However, the approach also accepts that people are fallible. They can become fatigued, inattentive, make poor choices or even choose to violate road rules deliberately. These human fallibilities will sadly and inevitably lead to collisions. However, in order to eliminate death and serious injury, measures taken within the Safe System approach dictate that those collisions must be of a severity that prevents the worst outcomes. Rather than unavoidable ‘accidents’, road incidents are seen as preventable collisions that have arisen due to a variety of factors. Understanding these factors and taking action to mitigate the known risks might stop such incidents happening in future<sup>14</sup>.

The Safe System recognises five interconnected areas of action to help minimise injury risk. They are:

- **Safe Roads and Roadsides:** designing roads (and their surroundings) to be more forgiving in the event of a crash. This involves features like roadside barriers, road surface maintenance and using road designs that minimise conflict between road users.
- **Safe Vehicles:** improving vehicle design to minimise injuries in the event of a crash. This includes features like airbags, crumple zones, and advanced driver-assistance systems (ADAS).
- **Safe Road Use:** promoting responsible behaviour by all those using the road system. This can involve education campaigns, driver training programs, and enforcement of traffic laws.

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<sup>14</sup> Note that in the early 2000s, UK police forces changed their terminology from ‘road traffic accidents’ (RTAs) to ‘road traffic collisions’ (RTCs) reflecting this view that road incidents are almost always preventable.

- **Safe Speeds:** recognising the critical role of speed in crash severity. Strategies include setting appropriate speed limits, implementing traffic calming measures, and educating drivers about the dangers of speeding.
- **Post-Crash Response:** achieving a swift and effective emergency response to minimise fatalities and injuries after a crash. This includes ensuring rapid communication of incidents, well-equipped ambulances and trained medical personnel.

The ultimate ambition of the Safe System is to eliminate death and serious injury from the road network, known as 'Vision Zero'. Given the amount of driving that takes place every day (around a billion vehicle miles every single day in the UK alone<sup>15</sup>) and the huge range of factors that can influence risk, this is undoubtedly a stretching ambition. Many find it difficult to imagine a world where zero can truly be achieved in such a complex and dynamic system and without curtailing personal freedoms in ways that society may consider unacceptable. However, the Safe System approach encourages a deeper consideration of all of the sources of that risk that exist and the potential techniques that might be applied to manage them.

The success and logical appeal of the Safe System has led to its adoption far beyond its Swedish origins. The United Nations and World Health Organization promote the Safe System as the preferred approach to improve road safety whilst public sector bodies such as the Department for Transport, Transport Scotland, Transport for Wales, Transport for London, Transport for West Midlands and National Highways all reference the Safe System as the framework they apply for improving road safety in their respective domains.

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<sup>15</sup> Department for Transport - Road Traffic Summary Statistics: <https://roadtraffic.dft.gov.uk/summary>

## Appendix B: Reviewing previous examples

Two recent fatal crashes provide examples of PFDs, showing the matters of concern identified and the stakeholders that the coroner felt were able to act in response.

### Charlie Hopkins and William Robinson (2021)

This incident involving the deaths of two teenagers on a local road in Surrey resulted in national television coverage to support proposals for progressive driver licensing. The driver (Hopkins, 18 years old) and front seat passenger (Robinson, 17 years old) died after Hopkins caused the vehicle (Volkswagen Polo) to hit the nearside kerb and was deflected into the opposing lane where it collided head-on with a Ford van.

The incident occurred on 26<sup>th</sup> September 2021 and an inquest opened in October 2021, paused due to court activity and was concluded in April 2024.

The Volkswagen Polo was being driven above the 30mph speed limit and Hopkins was under the influence of alcohol at the time of the collision. The coroner indicated that both were likely to have contributed to the cause of the collision.

Troublingly, the investigation also identified that the instrument cluster of Hopkins' vehicle had been tampered with during previous ownership following a fault that occurred in August 2013. The airbag warning light was obscured, hiding the fact that the airbags would not be triggered in the event of a collision – and which could have mitigated the forces of the impact in this collision.

The Surrey coroner published the PFD report in May 2024<sup>16</sup>, specifying three matters of concern:

- The incident occurred just over two weeks after Hopkins had passed his driving test. The coroner invited consideration of whether additional measures could mitigate the risk for young, new drivers.
- The failure of standard MOT tests to include diagnostic tests that would detect faults in safety critical equipment.

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<sup>16</sup> Charlie Hopkins and William Robinson: Prevention of future deaths report (2024) <https://www.judiciary.uk/prevention-of-future-death-reports/charlie-hopkins-and-william-robinson-prevention-of-future-deaths-report/>

- The failure of regular vehicle servicing to include diagnostic tests that would detect faults in safety critical equipment.

The coroner identified three recipients to which the PFD report was sent. They were:

- The Secretary of State for Transport
- The Chief Executive of the Driver and Vehicle and Standards Agency (DVSA)
- The Chief Ombudsman at The Motor Ombudsman

This reflects the role of the Department for Transport and DVSA in setting out the requirements for driver and vehicle certification and The Motor Ombudsman in maintaining standards in automotive trading and maintenance and in protecting consumer interests.

#### *Safe System review*

Extending the Safe System consideration of the incident, there may be other learning points that may prevent future deaths:

- **Safe Roads** e.g. the road layout and surface friction may have influenced the driver's speed choice and positioning.
  - o **Potential recipients** – road authorities
- **Safe Vehicles** e.g. intelligent speed assist (a feature to help drivers keep to posted speed limits) and / or alcohol ignition interlock (a device to prevent the vehicle being started if the driver is detected as having consumed alcohol), may have reduced the likelihood of the driver losing control of the vehicle (in addition to the additional diagnostic checks during scheduled maintenance suggested by the coroner).
  - o **Potential recipients** – Department for Transport, Vehicle Certification Agency, Driver and Vehicle Standards Agency.
- **Safe Road Use** e.g. road safety campaigns may have helped produce more conscientious driving (in addition to the progressive licensing approach suggested by the coroner).
  - o **Potential recipients** – Department for Transport, road safety campaign groups.
- **Safe Speeds** e.g. a lower speed limit at the incident location may have encouraged the vehicles involved to adopt slower speeds, reducing crash likelihood and severity.
  - o **Potential recipients** – road authorities

- **Post-Crash Response** e.g. a faster response by better equipped emergency services could have prevented Robinson's serious injuries from becoming fatal.
  - **Potential recipients** – emergency services, NHS

### *Amal Ahmed (2023)*

This incident gained high profile coverage<sup>17</sup> due to the coroner's suggestion that road signs needed to be improved at a junction. In November 2023, Ms. Ahmed mistakenly drove the wrong way onto the exit slip road of the A5 dual carriageway near Milton Keynes. Arriving onto the A5 in the wrong direction, Ahmed was in a head-on collision with another driver travelling at speed in the correct direction on the A5, resulting in the death of both drivers.

The Milton Keynes coroner published the PFD report in December 2023 before the inquest. The matter of concern identified by the coroner related to a perceived inadequacy of road signs and markings to denote the road as 'No Entry'.

The coroner identified two recipients to which the PFD report was sent. They were:

- The Chief Executive of Milton Keynes Council
- The Chief Executive of National Highways

This reflects the roles of the two organisations in managing road infrastructure at the incident location.

### *Safe System review*

Again, extending the Safe System consideration of the incident, there may be other learning points that may prevent future deaths:

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<sup>17</sup> BBC News (2024) A5 signs need improvement after deaths near Milton Keynes – coroner <https://www.bbc.co.uk/news/uk-england-beds-bucks-herts-67884582>

- **Safe Roads** e.g. systems exist for the automatic detection of wrong way driving<sup>18</sup> that could have enabled warning information to have been provided; the road geometry could have discouraged wrong way driving more intuitively and if the risks associated with this layout were present due to design standards, then those risks may be present in other locations around the road network.
  - **Potential recipients** – road authorities
- **Safe Vehicles** e.g. vehicles could be geofenced with alerts to warn drivers (and roads authorities) if they are travelling in the wrong direction.
  - **Potential recipients** – Department for Transport, vehicle manufacturers, Tier 1 automotive suppliers
- **Safe Road Use** e.g. where used, navigation systems could provide drivers with warnings if it is detected that they are erroneously travelling against the flow of traffic or if wrong way driving had been detected by another driver in their vicinity; records of wrong way driving recorded by other organisations (e.g. local road authority, police, recovery operators etc.) should be shared to identify locations with a high risk of wrong way driving.
  - **Potential recipients** – navigation system providers, vehicle manufacturers, emergency services, recovery operators, road authorities
- **Safe Speeds** e.g. a slower speed on approach to the wrong way slip road may have given Ahmed sufficient time to recognise the no entry signs and road markings present at the junction.
  - **Potential recipients** – road authorities
- **Post-Crash Response** e.g. a faster response by better equipped emergency services travelling to a closer emergency hospital could have prevented the other driver's serious injuries from becoming fatal.
  - **Potential recipients** – emergency services, NH

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<sup>18</sup> For example, (i) Navtech Radar (<https://navtechradar.com/problems-we-solve/intelligent-transport-systems/automatic-incident-detection/wrong-way-driver-detection/>) and (ii) Bosch (<https://www.bosch-mobility.com/en/solutions/assistance-systems/cloud-based-wrong-way-driving-warning/>)



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