REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1.

Cumbria County Council, Highways and Transportation, Parkhouse Buliding, Baron Way, Kingmoor Business Park, Carlisle. CA6 4SJ

1 CORONER

I am David Llewelyn Roberts, Senior Coroner, for the coroner area of North and West Cumbria.

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 2 September 2012 I commenced an investigation into the death of Matthew Thomas Hamilton. The investigation concluded at the end of the inquest on 2 August 2013. The conclusion of the inquest was:-

1a) Neck and Chest Injuries due to Road Traffic Collision.

4 CIRCUMSTANCES OF THE DEATH

On the 2nd September 2012 the deceased was riding his pedal cycle on the footpath (No 109392) linking Harraby Grove and Brunel Way, Carlisle. As he emerged onto Brunel Way he braked sharply as a car approached from his right. He was thrown over the handlebars. Both he and the cycle struck the side of the car. He sustained fatal injuries.

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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The MATTERS OF CONCERN are as follows. -

There is no barrier or restriction at the end of the footpath, such as are commonly found on footpaths or at school gates. The pavement is only some 1.5metres wide. This

	means that children whether on foot or otherwise can emerge suddenly at speed straight into the line of traffic. It was also noted that the taller metal fence and shrubbery restrict the vision of both footpath and road users. These represent hazards which should be looked into, and some action might be taken to reduce the risk of future deaths.
6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe 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 2 nd October 2013. 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 SAFEGUARDING BOARD.
	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	7 th August 2013 Signed