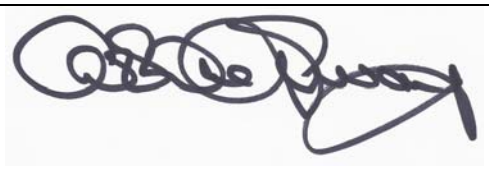
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. Island Roads, Isle of Wight** **2. The Highways Manager, Isle of Wight Council, County Hall, Newport, Isle of Wight** **3. [redacted], Hampshire Constabulary**
1	**CORONER** I am Caroline Sarah Sumeray, Senior Coroner for the Coroner Area of the Isle of Wight.
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 23rd October 2013 I commenced an investigation into the death of William John Watson, aged 93. The investigation concluded at the end of the inquest on 18th March 2014. The conclusion of the inquest was that William John Watson had died as the result of a road traffic collision. The medical cause of death was found to be: 1a Multiple Traumatic Injuries. 2 Stenotic Coronary Atherosclerosis.
4	**CIRCUMSTANCES OF THE DEATH** 1) William John Watson was born on 22nd March 1920. At the time of his death, he was 93 years of age. 2) He was in generally good health for his age. 3) On 22nd October 2013, at about 8.30 a.m. he was driving his car, a blue Ford Fiesta, along the Middle Road, Isle of Wight, in an easterly direction towards Newport. He was following behind a car which was following behind a single decker coach which was on a school run.

	4) The road was subject to the national speed limit and is a single carriageway. Evidential accounts about the weather at the time varied, but it started to rain around the time of the collision. Visibility was good. 5) The car immediately in front of Mr Watson pulled out and overtook the coach safely and without incident. 6) As the coach indicated and began to slow down to collect a pupil waiting at a bus-stop, Mr Watson edged out to see if it was safe to overtake the coach. Initially it was unsafe, and he pulled back in behind the coach. 7) As the coach was almost at the bus-stop, Mr Watson pulled out from behind the coach to overtake it. Witnesses did not recall seeing his offside indicator being used. 8) As he was level with the coach, Mr Watson was struck head-on by another vehicle, a black VW Polo, driven by [redacted] which was travelling at approximately 40 mph in the opposite direction. 9) Both drivers were seriously injured and had to be cut from their vehicles by the emergency services. 10) Mr Watson's condition visibly deteriorated prior to being released from his vehicle and he was airlifted to Southampton General Hospital where he died in the Emergency Department at 11 a.m. later that day.
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: – 1. During the course of the evidence, it became clear that there had been other road traffic incidents along this stretch of the Middle Road, and it was a matter of concern that the layout of the road, and surrounding hedgerows, adjacent to the bus stop at Tapnell, on the Newport bound carriageway, might be affecting drivers' visibility and thereby the safety of the road itself.
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 28th May 2014. 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: the family of William John Watson. 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	 **H.M. Senior Coroner – Isle of Wight** **2nd April 2014**