ANNEX A

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:-** **The Highways Agency**
1	**CORONER** I am Caroline Beasley-Murray, senior coroner, for the coroner area of Essex
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 3 December 2015 I commenced an investigation into the death of Keith John Charles Harper aged 59 years. The investigation concluded at the end of the inquest on 18 April 2016. The conclusion of the inquest was that Keith John Charles Harper died as a result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** On 21 November 2015 Mr Harper was a pedestrian exiting a footpath which crosses the central reservation when he was struck by a Renault Clio which was travelling on the A132 Southmayne in the general direction of Pitsea. He was taken to Broomfield Hospital and then transferred to the Royal London Hospital. He died there on 2 December 2015.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) A driver exiting the roundabout has no prior warning of the crossing. From the driver's position the aspect view of the pedestrian/cycle path is limited and the central reservation presents itself as a grassed area. A review should be carried out of features of the pedestrian crossing – warning signs/design/position etc etc (2) The carriageway markings exiting the roundabout have been obscured by resurfacing work and road debris. This work needs to be carried out
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you and 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 11th June 2016. 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 family of Mr Harper and to Essex Police 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	**21 April 2016** **Caroline Beasley-Murray**