

Stephen John Nicholls Assistant Coroner for The County of Dorset

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
THIS REPORT IS BEING SENT TO: Dorset Highways Department
CORONER
I am Stephen John Nicholls, Assistant Coroner for The County of Dorset
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.
INVESTIGATION and INQUEST
On 26/01/2016 I commenced an investigation into the death of Reverend Colin Hodge, 76. The investigation concluded at the end of the inquest on 20 February 2017. The conclusion of the inquest was Road Traffic Accident.
Medical cause of death – 1a Head Injury 1b Road Traffic Accident
CIRCUMSTANCES OF THE DEATH
On the 19 th January 2016 Reverend Hodge was walking along the High Street in Wareham and approached the junction of Howards Lane. The pavement was in a poor state of repair and there was no clear indication where the pavement ended and the road began. A motor vehicle was indicating and was slowly making a right angled turn to its left to enter into Howards Lane. According to the evidence of witnesses it appeared that Reverend Hodge saw the motor vehicle. Findings made at the Inquest were that Reverend Hodge stumbled on the uneven surface and fell against the side of the motor vehicle. The impact caused Reverend Hodge to fall to the ground whereby he struck his head. He was taken to hospital and died on the 25 th January as a result of the head injury that was inoperable.
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) The evidence from the witnesses who were all from the Wareham area, was that the pavement and road way at the junction of the High Street and Howards Lane was in a poor state of repair. (2) At the time of the incident, the pavement and roadway were all of one level. (3) Evidence from the witnesses indicated that this junction was of concern for two reasons; Firstly that pedestrians would walk straight across as there was no clear boundary between the pavement and the road; Secondly, as the entrance to Howards Lane is narrow, cars would

6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you, Dorset Highways 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 26 April 2017. 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,
	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	Dated 28 February 2017
	Signature Solver Stephen John Nicholls Assistant Coroner for The County of Dorset