

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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	<p>THIS REPORT IS BEING SENT TO:</p> <p>[REDACTED]</p> <p>Strategic Transport Manager Reading Borough Council</p>
1.	<p>CORONER</p> <p>I am Emma Jones, Assistant Coroner for Berkshire.</p>
2.	<p>CORONER'S LEGAL POWERS</p> <p>I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.</p>
3.	<p>INVESTIGATION and INQUEST</p> <p>On the 25th May 2016, the Senior Coroner, Peter Bedford, commenced an Investigation into the death of Malcolm Langford. I concluded the investigation by way of a one day inquest on the 2nd day of March 2017.</p> <p>I concluded that death was due to road traffic collision.</p>
4.	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On the 14th day of May 2016, at approximately 10:30am, Mr Langford was walking along Albert Road, Caversham, Berkshire, with his wife.</p> <p>Albert Road is a residential road with two lanes, one in either direction, and is subject to a statutory speed limit of 30mph.</p> <p>There are a number of roads leading off Albert Road, one of which is Highmoor Road.</p> <p>The junction of Highmoor Road with Albert Road is marked by a stop sign, solid white lines and a section of red tarmac. The junction has restricted visibility due</p>

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to houses on either side, fences and trees.

Vehicle 1 was driving along Albert Road, in the direction of Mr Langford.
Vehicle 1 was driving within the speed limit.

Vehicle 2 approached the junction with Albert Road from Highmoor Road.
Vehicle 2 started to pull out of the junction and collided with vehicle 1, causing it to veer off course.

Vehicle 1 crossed the opposite carriageway, mounted the pavement and collided with Mr Langford, knocking him into the road. He sustained a non-survivable head injury and died the same 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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows: –

During the inquest, the court heard evidence from [REDACTED] Forensic Collision Investigator for Thames Valley Police. He attended the scene shortly after the collision and examined the junction. His evidence was that visibility at the junction is restricted, particularly when looking to the right, due to a house with a large fence and trees. The following four important points were elicited during the inquest:

- (1) a vehicle stopped at the stop line on Highmoor Road is first able to see the front offside corner of a vehicle travelling north along Albert Road at a distance of about 35 metres;
- (2) a vehicle stopped at the stop line on Highmoor Road is first able to see the full width of the front of a vehicle travelling north along Albert Road at a distance of about 24 metres;
- (3) if a vehicle is travelling at 30mph along Albert Road, it will take only 2.6 seconds from being completely out of view of drivers on Highmoor Road to reaching the junction. It will take only 1.8 seconds from the time that the front of the vehicle is visible until it reaches the junction;
- (4) given a typical rate of acceleration, it is not possible for a 'normal' driver in a 'normal' car to pull safely out of Highmoor Road junction even when Albert Road appears to be clear. The only way to negotiate the junction safely is to edge forward, maintaining a constant look-out.

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Mr Henderson was of the opinion that the junction could be improved by bringing it forward, thereby increasing visibility along Albert Road, and reducing the likelihood of further collisions.

6. ACTION SHOULD BE TAKEN

In my opinion urgent action should be taken to prevent future deaths and I believe your organisation has 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 **12th June 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 following:

- the Chief Coroner of England & Wales
- [REDACTED] wife of Malcolm Langford

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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9. Dated this 31st day of March 2017


Peter J. Bedford
Senior Coroner for Berkshire

on behalf of *Suzanne Jones*