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.** Debbie Ward, Chief Executive of Dorset County Council, County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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 the 20th October 2016, an investigation was commenced into the death of Aaron George Nordass-Lacey, born on the 6th July 1995. The investigation concluded at the end of the Inquest on the 24th January 2018. The Medical Cause of Death was: 1a Head and Chest Injuries The conclusion of the Inquest was that Aaron George Nordass-Lacey died when he fell from his bicycle and was struck by a motor vehicle, but the sequence of events as to how he sustained his injuries is unclear, even on the balance of probabilities.
4	**CIRCUMSTANCES OF THE DEATH** On the 13th October 2016, the deceased was riding his father's Corratec X-vert Cross Pedal Cycle along the A35, Barrack Road, Christchurch at Bailey Bridge. He made his way onto the central reservation of that road and fell from his bike towards the carriageway into the path of an oncoming motor vehicle. He sustained unsurvivable injuries to his head and chest and despite being taken to the Royal Bournemouth Hospital, Bournemouth, his death was confirmed there a short time later that day. The sequence of how he sustained his injuries is not clear, whether he hit the ground before he was struck by the car, whether the car struck him before he hit the ground, or whether both occurred at the same time.

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 inquest evidence was heard that:

   i. The road where the incident occurred that lead to Aaron's death, the A35 Barrack Road, Christchurch, Dorset is a road which has a speed limit of 30 miles per hour. Evidence was given that people regularly drive at excessive speeds on this road. The location of the incident is near to a school and evidence was given that people, especially school children, do not always use the designated crossing just prior to the junction of Clarendon Road and Barrack Road. Evidence was given that school children often flood out of the school and run into the road. Evidence was given that this was perceived to be a danger and that there could be the death of a person in the future.

   ii. The placement of barriers along this section of road would assist in reducing the access to the road and encouraging pedestrians to use the crossing to cross the road safely, reducing the potential dangers and risk to life. It was also suggested that a fixed speed camera may assist in regulating the speed of vehicles that use the road.

   iii. Evidence was also given in relation to the cycle lane along Barrack Road. The cycle lane along Barrack Road heading towards Christchurch is on the footpath and is a shared cycle lane and footpath. The cycle lane comes to an end just before the junction of Clarendon Road and evidence was given by the Collision Reduction Team Manager that the expectation is that when the cycle lane comes to an end, cyclists will cross the road and use the cycle path on the footpath on the other side of the road. Although there is a sign at the end of the cycle lane it is not clear that the expectation is for the cyclist to cross over the road at the crossing. The lack of signage is therefore very confusing and could lead to a further collision.

2. I have concerns with regard to the following:

   i. The safety of pedestrians and cyclists who use Barrack Road, Christchurch where the incident that led to Aaron's death occurred. I would therefore request that there is a review of the safety measures in place and consideration is given to the erection of barriers along the pavement and also along the central reservation to discourage pedestrians and cyclists from crossing the road in a dangerous manner.

	ii. I would also request that a review is undertaken regarding the signage given to cyclists at this location and consideration be given to having a fixed speed camera at this location.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, 28th March 2018. 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: (1) [redacted], BPS Law LLP, Cardinal House, 20 St Mary's Parsonage, Manchester, M3 2LY (2) [redacted] Browne Jacobson LLP, 1 Manor Court, Dix's Field, Exeter, EX1 1UP, on behalf of [redacted] 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** **31st January 2018**
	Signed **Rachael C Griffin**