

## Robert Turnbull Senior Coroner for Western Area of North Yorkshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:  1) Richard Flinton, Chief Executive, North Yorkshire County Council 2) Chief Coroner 3)
1	CORONER
	I am Robert Turnbull, Senior Coroner for Western Area of North Yorkshire
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
	On 26 <sup>th</sup> September, 2018, I commenced an investigation into the death of Luke John Saxton. The investigation concluded at the end of the inquest on 26 November 2018. The conclusion of the inquest was Luke John Saxton died of multiple injuries as a result of an accident.
4	CIRCUMSTANCES OF THE DEATH
	At about 23:10 hours, 23 <sup>rd</sup> June, 2018, Luke John Saxton was walking along the A59 at a point near to the Bull at Broughton public house. It was dark at the time and there was no street lighting at that location. Mr Saxton was struck by a motor car travelling in the direction of Barnoldswick. The driver of the motor car, although displaying dipped headlights, had been unable to see him until too late to avoid the collision. Mr Saxton died at the scene from injuries sustained.
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. —
	The collision occurred in darkness in an area where there was no street lighting;     Mr Saxton had been attending a wedding at nearby Broughton Hall, a popular wedding venue;
	3) There are bus stops in the area where the collision occurred which were also in
	darkness; 4) Consideration should be given to erecting street lighting to cover the area where the collision occurred up to the bus stops at either side of the Bull at Broughton public house.

6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you
	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 25 January 2019. 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 29 November 2018
	Do Tabuer
	Senior Coroner for Western Area of North Yorkshire
	Genior Coroner for vvesterii Area or North Forkshire