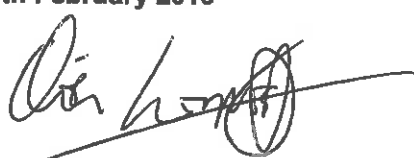


ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. [REDACTED] Head of Highways Infrastructure, Leeds City Council, Middleton Complex, Middleton Ring Road, Leeds, LS10 4AX</p>
1	<p>CORONER</p> <p>I am Oliver Longstaff, Assistant Coroner, for the Coroner area of West Yorkshire (East)</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 16 January 2018 an investigation was commenced into the death of Hoshi Jane Naylor, aged 12. The investigation concluded at the end of the Inquest on 15 February 2019. The conclusions of the Inquest were that Hoshi died on 11 January 2018 in Leeds General Infirmary from the effects of a severe traumatic brain injury sustained in a road traffic incident on 4 January 2018, and that this was a death due to a road traffic collision.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>At around 1825 hours on 4 January 2018, Hoshi was crossing the A6120 Leeds outer ring road when she was struck at a point close to the A6120/A58 roundabout by a car travelling on the eastbound carriageway. She sustained unsurvivable injuries, and died a week later in Leeds General Infirmary.</p>
5	<p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>(1) The point at which Hoshi started to cross the road is approximately opposite a bus stop and a shop which she was intending to visit to buy packed lunch provisions for a school trip the following day. It is a point where pedestrians can reasonably be anticipated to cross the road to and from the bus stop and the shop.</p> <p>(2) The nearest pedestrian refuge island to the scene of the collision is approximately 500 metres away from it, in an eastbound direction.</p> <p>(3) The nearest traffic signal controlled pedestrian crossing to the scene of the collision is approximately 940 metres away from it, in an eastbound direction.</p> <p>(4) In the opinion of a Forensic Collision Investigator called as an expert witness to the Inquest, the provision of facilitated pedestrian crossing points on this stretch of the A6120 (whether facilitated by refuge islands or pedestrian crossings) is sparse in</p>

	<p>comparison to such provision on similar stretches of the A6120 elsewhere along its length.</p> <p>(5) The street lighting at the collision site appears to offer little illumination of the grass verges to either side of the road. In dark conditions, motorists' awareness of pedestrians intending to cross the road is likely to be restricted.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 24 April 2019. I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons : Hoshi's parents [REDACTED] West Yorkshire Major Collision Enquiry Team; and to the Local Safeguarding Children Board at Leeds.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>27th February 2019</p> <div style="display: flex; justify-content: space-between; align-items: center;">  <div style="text-align: right;"> <p>Oliver Longstaff Assistant Coroner West Yorkshire (Eastern)</p> </div> </div>