REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Derbyshire County Council;** **2. Chief Coroner;** **3. Family of the deceased.**
1	**CORONER** I am Emma Serrano, Assistant Coroner, for the coroner area of the Derby and Derbyshire.
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 25th September 2018, I commenced an investigation into the death of Mr Thomas Andrew Reid. The investigation concluded at the end of the inquest on 28 June 2019. The conclusion of the inquest was a short narrative conclusion of: Road Traffic Collision. The cause of death was: 1a Traumatic Brain Injury; 1b Skull Fracture; and 1c Road Traffic Collision
4	**CIRCUMSTANCES OF THE DEATH** i) Mr Reid was a 27 year old gentleman who was driving his motorbike along the A515 near to Sudbury in Ashbourn, with the junction of the B5033 (Cockshead Lane). During this journey he came across a queue of traffic. Mr Reid started to overtake the queue of traffic and had a road traffic collision with a tractor being driven by another. The tractor was in the process of completing the manoeuvre of turning right into the B5033. ii) He sadly died from the injuries, at the roadside on the sustained on the 21 September 2018. iii) It would appear that Mr Reid did not see the route marker board 155 meters from the junction which is the only advanced warning of the junction ahead. The location and scale of the sign mean that it could be obscured by passing large vehicles, such as LGV's, especially if they are slow moving. iv) Also that the A515 has recently been resurfaced, with central white lines and marginal white lines also having been renewed. The B5033 had not had any surface dressing applied and the white lines defining the mouth of the junction has not been renewed. The existing markings that remained

	were excessively worn and very feint, which made it less easy for motorists to define the mouth of the junction when travelling along the A515.
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. Evidence emerged during the inquest that there were at least two previous incidents along that part of the road. Once causing fatal injuries and one causing critical injuries. Additionally numerous other minor incidents. 2. The route marker board 155 meters from the junction, is the only advanced warning of the junction ahead. The location and scale of the sign mean that it could be obscured by passing large vehicles, such as LGV's, especially if they are slow moving. This happens often given the presence of the junction. 3. Evidence also emerged at the inquest that Derby County Council was aware of the issue and were looking at more signage, larger signs and additional pre-warning signs. This was discussed last October at a Derbyshire County Council meeting. It was not known what, if anything, Derbyshire County Council would do about this known risk.
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. 1. You may wish to consider further reviewing the signage on the road and what remedies should be put in place to reduce the risk of further Road Traffic collisions along the A515.
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 August 2019. 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; Family. 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	[redacted] **Miss Emma Serrano** **Assistant Coroner** **Derby and Derbyshire Coroners Area**