REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Cheshire East Highways Department** **2. Chief Executive, Cheshire East Council**
1	**CORONER** I am Mrs Jean Harkin assistant coroner, for the coroner area of Cheshire.
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 6 November 2018 I commenced an investigation into the deaths of Liyakat Ali SIDAT, aged 47 years, Salma Bibi SIDAT, aged 41 years and Hajra Bibi SIDAT, aged 14 years. The investigation concluded at the end of the inquest on 23 October 2019. The conclusion of the inquest was Road Traffic Collision in all three deaths. Multiple injuries represented the main feature in all medical causes of death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Liyakat Ali Sidat was driving his vehicle, a Toyota Yaris, on the A34 Melrose Way towards Wilmslow, also known locally as the Alderley Edge Bypass on the 4 November 2018. Mr Sidat overtook 2 vehicles on a bend and collided with an oncoming vehicle. Mr Sidat, his wife and his daughter sustained fatal injury.
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) The A34 bypass (Melrose Way Bend) presents a danger to life. (2) The Melrose Way section has no continuous white line at the bend section preventing overtaking. (3) Other coroners have issued Regulation 28 Reports yet there has been no implementation of any new measures. It is dangerous to overtake on that stretch of road witness evidence referred to how dark it was and lives are at risk if overtaking is allowed to continue there.
6	**ACTION SHOULD BE TAKEN** In my opinion 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, namely by 26 December 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: 1. The Sidat family 2. Local Safeguarding Board where the deceased was under 18. 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	**1 November 2019** **Jean Harkin, Assistant Coroner**