


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> <ol style="list-style-type: none">1. Mr Graham Farrant, Chief Executive, BCP Council, Town Hall, Bournemouth2. [REDACTED], Street Lighting Engineer, Growth and Infrastructure, BCP Council, Civic Centre, Poole
1	<p>CORONER</p> <p>I am Brendan Joseph Allen, Assistant Coroner, for the Coroner Area of Dorset.</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 the 4th December 2018, an investigation was commenced into the death of Beryl Fricker, who was born on 4th March 1944.</p> <p>The investigation concluded at the end of the Inquest on the 14th January 2019.</p> <p>The Medical Cause of Death was:</p> <p>Ia Head Injury</p> <p>The conclusion of the Inquest was that Beryl Fricker died as a consequence of a road traffic collision.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>At approximately 4.30 pm on 20th November 2018, Mrs Fricker was a pedestrian on Lake Road in Poole, walking towards Blandford Road. It was dusk, and the street lamps were illuminated. I heard evidence that the vehicles travelling along Lake Road had their headlights illuminated. As Mrs Fricker was crossing Upwey Avenue, she was struck by a Toyota Yaris being driven by [REDACTED]. [REDACTED] was turning right into Upwey Avenue from Lake Road. Bystander CPR was commenced and paramedics attended. Mrs Fricker was taken to Southampton Hospital where she sadly died of her injuries on 30th November 2018.</p>

5	<p><u>CORONER'S CONCERNS</u></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. The MATTERS OF CONCERN are as follows:</p> <ol style="list-style-type: none"> 1. During the inquest, the following evidence was heard: <ol style="list-style-type: none"> i. [REDACTED] the driver of the Toyota Yaris, explained that she did not see Mrs Fricker as she turned into Upwey Avenue. She gave evidence that the street lighting at the junction is poor, which was reiterated to her by members of the public who spoke to her after the collision. In addition, I heard evidence from 2 further witnesses that the street lighting at the junction was poor. One of those witnesses was [REDACTED] a Royal Marine Medic, who was returning home from work and drove passed the collision site. [REDACTED] was one of the member of the public who was able to provide treatment to Mrs Fricker before the arrival of the paramedics. He was independent of all those directly involved in the collision. 2. I have concerns with regard to the following: <ol style="list-style-type: none"> i. Upwey Avenue is a wide junction, with the nearest street lamps some distance from the junction itself. As a consequence the middle of the junction appears to be the least well illuminated section of that stretch of road. The surrounding area is residential and there are a number of local schools, including infant and secondary schools, so there is likely a significant number of pedestrians, cyclists and other road users travelling along Lake Road. ii. I request that, to prevent future deaths, consideration is given to the street lighting at the junction of Lake Road and Upwey Avenue and whether improvements can be made to better illuminate the junction for all road users.
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</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 25th March 2020. I, the coroner, may extend the period.</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.	
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:</p> <p>(1) [REDACTED] daughter of Mrs Fricker; (2) [REDACTED] driver of the Toyota Yaris.</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>Dated</p> <p>28th January 2020</p>	<p>Signed </p> <p>Brendan J Allen</p>