

+REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: ██████████ General Highways Manager and Councillor Andrew Reid, Cabinet Minister for Highways, Transport and Rural Affairs, at Suffolk County Council.</p>
1	<p>CORONER</p> <p>I am Jacqueline Devonish, Area Coroner, for the coroner area of Suffolk.</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 December 2019 I commenced an investigation into the death of Jamie Finlay.</p> <p>The investigation concluded at the end of the inquest on 16 December 2019. The conclusion of the inquest was that Jamie Finlay died whilst a passenger of a car which had been driven at speed without braking to avoid a collision with an oncoming vehicle which was turning right before a filter lane bollard on the A1088 junction with Thetford Road, Ixworth.</p> <p>The medical cause of death was: 1a. Raised intracranial hypertension 1b. Traumatic Brain Injury 1c. Road Traffic Collision</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On 8 May 2017 Jamie Finlay had been collected from home in Woolpit at around 6.16am by his work colleague to drive to Thetford to meet the works vehicle. They journeyed through Norton Village to the A1088 where the colleague drove at the speed limit of 60mph. Jamie's colleague did not brake as he approached a sweeping bend at the junction with Thetford Road and was perhaps going too fast to avoid a collision with another oncoming vehicle negotiating a right turn from the filter lane. Both drivers swerved to avoid the other. The colleague swerved to the wrong side of the road colliding with the other drivers' passenger front and side, whilst the other driver swerved to his left into the collision and suffered similar damage to the front left.</p> <p>The other driver had attempted to take the right turn into Thetford Road on the wrong side of the bollard, where there was a clear view into Thetford Road from the A1088 and a wide radius for undertaking such a manoeuvre. He swerved back into the A1088 when he saw the car, in which Jamie Finlay was a passenger, appear around the bend prior to the junction.</p> <p>Jamie Finlay was transported from the scene to Addenbrooke's Hospital where his life support was switched off on 11 May 2017 at 15:59 hours.</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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The MATTER OF CONCERN is as follows:-</p>

	<p>The design of the filter lane and junction from the A1088 to Thetford Road does not prevent drivers turning right ahead of the bollards, and onto the wrong side of those bollards into Thetford Road.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you 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 25 February 2020. I, the Area Coroner, may extend the period if I consider it reasonable to do so.</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:</p> <p>██████████ ██████████ ██████████</p> <p>I am 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 Area Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.</p>
9	<p><i>Jacqueline Devonish</i> 17 December 2019</p>