REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Highways Authority, Cornwall Council**
1	**CORONER** I am Andrew Cox, the Acting Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 27/1/21, I concluded an inquest into the death of Aaron Antony Lauder, 38, who died in a road traffic collision on the A30 near Higher Drift Farm, Penzance. . The medical cause of death was recorded as: 1a) Displaced Basal Skull Fracture Traversing Middle Cranial Fossa Vault with Underlying Traumatic Brain Injury Cerebral Oedema; Bilateral Rib Fractures Complicated by Flail Segment, Pneumothorax and Multiple Pulmonary Lacerations 1b) Blunt Force Head and Chest Trauma 1c) Motor vehicle collision II) I recorded a Conclusion of Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** Mr Lauder was riding his Kawasaki motorbike along the A30 in an easterly direction from St Buryan towards Penzance. At the scene of the collision, a John Deere tractor was turning right in a westerly direction across Mr Lauder's path. The national speed limit of 60mph is in force at the location. The Collision Investigator recorded that there was a 'distinct lack of view to the right especially given the speed limit' available to the tractor driver. The view was similarly restricted for Mr Lauder.
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. I concluded that the prime cause of the collision was the lack of view available to either driver at the accident locus.
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. While it is the Highway Authority who has the expertise in how to improve road safety at the junction, it seems to me there are a number of steps that may sensibly be considered: - The hedge obstructing the view could be taken down. If Cornwall Council is not the landowner of the hedge, could you kindly provide me with the name and

	contact address of the owner so I may write to them in similar terms; - The 30mph speed limit that begins at the outskirts of the village of Drift could be extended in a westerly direction to include this junction and the bend immediately preceding it when approaching from an easterly direction; - A suitably sized mirror could be placed in the hedge opposite the mouth of the junction so that drivers turning right could have a view of approaching vehicles otherwise out of sight behind the bend; - Rumble strips and/or a warning sign of a hidden junction could be placed on the carriageway or before the bend where the incident occurred.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 March. 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: [redacted] and his insurers. 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	**27.1.21** **Acting Senior Coroner**