REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Suffolk Highways** **2. National Highways**
1	**CORONER** I am Tim Deeming, Assistant Coroner, for the coroner area of Suffolk.
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 4th December 2020 we commenced an investigation into the tragic death of **Thomas Pickering** The investigation concluded at the end of the inquest on 19th August 2021. The conclusion of the inquest was that:- On the 26 August 2020 Mr Pickering left home at approximately 22.20 with his girlfriend as a passenger. He was driving his Kia car towards Maningtree train station on the A137 near Tattingstone, Ipswich in order for her to depart on the 22.54 train. At around 22.45 a road traffic collision occurred in the northbound lane near to Nine Oaks and Wallers Farm at the brow of the hill. The likely cause of this collision was due to the Kia overtaking a VW Golf despite the white lines, resulting in the collision with the oncoming Saab in an offset head-on impact. The speedometer of the Kia was recorded as 71mph and the speed limit at this section was 60mph. Emergency services were called and fire crew service support was provided given that the Kia was inverted due to the collision and Mr Pickering remained upside down in the driving seat. Following his release from the car, paramedic support was then able to be assessed but Mr Pickering was recognised as passing away at 23.45 at the scene of the collision due to massive multiple injuries sustained. The medical cause of death was confirmed as: **1a Massive Multiple Injuries** **1b RTC**
4	**CIRCUMSTANCES OF THE DEATH** Following on from the above and the Forensic Collision Investigator report I understand that the site of the incident already has solid white lines and a 60mph limit, however I heard that the area is a blind summit without signage or other warnings on approach, and the family understand that there have been other RTC's at the location.
5	**CORONER'S CONCERNS**

	During the course of the inquest the evidence revealed matters given 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; the **MATTERS OF CONCERN** as follows. – I am concerned as to whether further preventative steps can be taken to mitigate the risk of future RTC's at the site given the apparent lack of signage – eg hidden dips, or signage relating to notification of recent incidents at the area to increase awareness eg the number of fatalities/collisions.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15th October 2021 I, the Assistant Coroner, may extend the period if I consider it reasonable to do so. 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. Mr Pickering's next of kin. 2. Suffolk Police I am 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 Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**20 August 2021** **Tim Deeming**