ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **The Head of Plymouth Highways,** **Plymouth City Council,** **Plymouth,** **PL1 3BJ**
1	**CORONER** I am Deborah Archer, Assistant Coroner, for the coroner's area of Plymouth, Torbay and South Devon.
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 18th September 2020 I commenced an investigation into the death of Harry Edward Simmons age 87. The investigation concluded at the end of the inquest on 20th January 2021. The conclusion of the inquest was as accident, and the medical cause of death was 1a) Traumatic intracerebral haemorrhage with burst lobe and II) Complications of bilateral lower limb fractures in an elderly man.
4	**CIRCUMSTANCES OF THE DEATH** Mr Simmons was walking along the footpath on Beacon Hill Road, Plymouth PL2 3 LU and had got as far as crossing with the junction on Montpellier Road when a driver of a red Astra Motor vehicle came from the direction of Beacon Hill Road, turned right into Montpellier Road and struck Mr Simmons whilst he crossed Montpellier Road. The driver had cut the corner of the junction and instead of making a right hand turn into the left-hand side of Montpellier Road he had crossed into Montpellier Road by turning in on the incorrect right-hand side of the junction. As he did so he hit Mr Simmons who was ½ way across the road by the time the collision happened. As the driver struck Mr Simmons he fell to the floor and became trapped under the front wheel of the car. Mr Simmons died of his injuries later in hospital. The driver was prosecuted in the Magistrates court, and it was revealed during the police investigation that there was no defect in the car, the driver provided a negative breath test and also passed the eyesight test at the scene. The driver accepted that he had not seen Mr Simmons and he was driving the car on a bright sunny morning with his sun visor down, the driver was not speeding or otherwise in a hurry.

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 could 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) Acting Police Inspector [redacted] gave evidence to the inquest as follows: 1. In his opinion as Mr Simmons was at least ½ way across the road if the driver had not turned into the junction on the incorrect side of the road, he would have most likely avoided him 2. The sun is a particular hazard at that junction and would have had an effect on the ability of the driver to see Mr Simmons. 3. Double yellow lines in his opinion would not prevent a further accident of this nature. 4. A pedestrian refuge in the centre of the road on the junction of Montpellier Road and Beacon Park Road together with a keep left sign would prevent vehicles cutting the corner and causing a similar accident again. 5. There have been 3 collisions on this junction in the last 5 years, 2 of which have cited the sun as a contributory factor. 6. There is local knowledge to suggest that drivers cutting this corner is a commonplace occurrence as the sharp turn right to the correct side of the road is a more difficult manoeuvre to make.
6	**ACTION SHOULD BE TAKEN** In my opinion you should review the road safety measures at this junction and action should be taken to prevent future deaths and I believe you and 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 Thursday 31st March 2022. 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]. I have also sent it to Acting Police Inspector [redacted] of the Devon and Cornwall Constabulary who may find it useful or of interest. 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	 **Thursday 3rd February 2022** **[Deborah Archer, Assistant Coroner]**