REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **The Asset, Policy and Commissioning Manager,** **Suffolk Highways,** **3 Goddard Road,** **Ipswich,** **IP1 5NP**
1	**CORONER** I am Nigel Parsley, Senior 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 22nd November 2021 I commenced an investigation into the tragic death of **Ethan Jake WRIGHT** The investigation concluded at the end of the inquest on 21st July 2022. The conclusion of the inquest was that:- **Ethan Wright, a 16-year-old boy, died from the serious head injuries he suffered when the bicycle he was riding collided with a van, on the 17th November 2021 in Lowestoft, Suffolk.** **Despite undergoing emergency surgery, Ethan's injuries were not survivable, and he passed away the following day on the 18th November 2021** The medical cause of death was confirmed as: **1a Severe Traumatic Brain Injury** **1b Road Traffic Collision**
4	**CIRCUMSTANCES OF THE DEATH** Ethan Wright died at the Addenbrookes Hospital, Cambridge in Cambridgeshire on the 18th November 2021. Ethan had been admitted to the Addenbrookes Hospital on the 17th November 2021 following a collision between the bicycle he was riding and a van. The collision occurred in Higher Drive, Lowestoft in Suffolk at approximately 10:10am on the 17th November 2021. Ethan rode from a public bridle way (Woods Loke West) onto Higher Drive, where his bicycle hit the front nearside of the van, his head then hitting the near side A-pillar between the windscreen and passenger door. Ethan sustained serious injuries to his head and was subsequently airlifted to Addenbrookes hospital, where despite surgical intervention he tragically succumbed to his injuries the follow day.

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. – In evidence it was heard that the public bridleway, Woods Loke West, is predominantly used by pedestrians and cyclists. As part of the police investigation, photographs were provided that showed the area where Woods Loke West joins Higher Drive. Woods Loke West joins Higher Drive at approximately a 90-degree angle and vehicle access to the Loke is prevented buy two concrete bollards. These bollards are placed wide enough apart as to not cause a hinderance to either cyclists or pedestrians. When cycling from Woods Loke West onto Higher Drive, the view afforded of Higher Drive is severely restricted by fencing, and it is only once a cyclist or pedestrian is on the pavement of Higher Drive itself, are they afforded any view of the main road to their right. This is the direction of travel of the van with which Ethan collided. The police officer who investigated Ethan's tragic death, stated in evidence that there was no physical barrier, or any other measure in place, that would make a cyclist or fast-moving pedestrian slow down before entering Higher Drive. The police officer was particularly concerned about children using the Loke as a cycle path, as these young riders have a much lower perception of risk. The officer was of the opinion that some physical means of preventing direct access onto Higher Drive from Woods Loke West, or some other measure to ensure a cyclist or fast-moving pedestrian slowed down on approaching Higher Drive, would prevent a further tragedy at this location.
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 19th September 2022 I, the Senior 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. Ethan's next of kin. 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**25th July 2022** **Nigel Parsley**