REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Rt Hon Mark Harper MP, Secretary of State for Transport **2.** [redacted] Chief Executive Officer of National Highways Agency **3.** [redacted] Chief Constable of Dorset Police **4.** [redacted] Chief Executive of Dorset Council **5.** [redacted] Chief Executive of BCP Council
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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 the 10th June 2021, an investigation was commenced into the death of Stephen Robert Wood, born on the 18th March 1962. The investigation concluded at the end of the Inquest on the 07th February 2023. The Medical Cause of Death was: Ia Multiple injuries The conclusion of the Inquest was road traffic collision.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 19.13 hours on the 30th May 2021, the deceased was riding his Harley Davidson XL1200 motorcycle in a northerly direction along Coombe Road, Winterbourne Steepleton, Dorchester which has a speed limit of 60mph. He was travelling at a speed of no more than 44mph when he had just driven over the brow of a hill and his bike entered a 60 metre stretch of grass in the carriageway, which covered the entire width of the carriageway and had been there from at least approximately 18.00 hours that day. His motorcycle slipped on the grass, and he became separated from the motorcycle. He travelled into the pathway of an oncoming Ford Focus Titanium TDCI in the southbound carriageway of the road, which passed over him. He came to rest under the vehicle and sustained numerous significant and unsurvivable injuries.

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: 1. During the inquest evidence was heard that: i. On the 30th May 2021 a carpet of grass was obstructing the entire north bound carriageway of Coombe Road, Winterbourne Steepleton, Dorchester for a distance of 60 metres. This was described as dangerous and a hazard. On that day a road traffic collision occurred as a result of that hazard in which sadly Mr Wood died. ii. There was evidence that the grass had been seen at approximately 18.00 hours by a member of the public driving on the other side of the road. The collision occurred at approximately 19.13 hours. Between 18.00 hours and 19.13 hours, 3 people working on a local farm transporting sileage from a local field to the farm had seen the grass and had driven over it. Others may also have seen and/or driven over the grass. iii. No one reported this obstruction in the road prior to the collision. Evidence was given that there is a legal requirement to remove or report any spillage if you cause it, but there is no obligation to report any hazard you see, which you have not caused. iv. The owner of the farm, who was undertaking sileage transfer in the area at the time, has said that since the incident, if there is any spillage or obstruction he or his employees come across, they will report it, so it can be cleared. 2. I have concerns with regard to the following: i. That there is a lack of knowledge and/or understanding as to when people should report an obstruction in the road. I would request that consideration is given to making all road users aware of the dangers of obstructions in the road and to encourage them to report any hazard to the local Police force or Local Authority so that it can be removed as soon as possible, or at least other road users be warned of the hazard to prevent a future death.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I

	believe you and/or 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, 4th April 2023. 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 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	**Dated** **8th February 2023**	**Signed**  **Rachael C Griffin**