




Signed by **Geoffrey Sullivan**
Title **HM Senior Coroner**
Jurisdiction **Hertfordshire**

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>██████████ - Chief Executive of Hertfordshire County Council ██████████ - Chief Executive of National Highways ██████████ - UK Power Networks Holdings Ltd</p>
1	<p>CORONER</p> <p>I am Geoffrey Sullivan HM Senior Coroner for Hertfordshire</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p> <p>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 12th December 2021 Steven Easdale died at Addenbrookes Hospital from injuries sustained in a road traffic collision. His death was reported to the Coroner and an investigation commenced. A post-mortem examination performed by Dr Martin Goddard on 21st December 2021 provided the following cause of death:</p> <p>1a Purulent Bronchitis and Bronchopneumonia</p> <p>1b Multiple Traumatic Injuries</p> <p>An inquest was opened on 9th March 2022 and the investigation concluded at the end of that inquest on the 8th February 2023, which found:</p> <p>Circumstances:</p> <p>On the 5th November 2021 Steven Easdale was struck by a car whilst crossing the B197 Digswell Hill. He sustained multiple injuries and was taken by ambulance to Addenbrookes Hospital. Despite treatment, Mr Easdale died on the 12th December 2021. There was a central pedestrian island near to where Mr Easdale crossed the road but he did not use it. It was dark at the time Mr Easdale crossed, he was wearing dark clothing and the driver did not have time to react to his presence in the road and avoid the collision. The central pedestrian island near to where Mr Easdale crossed the road should have been illuminated. It was not in working order, however, and was therefore unlit. A nearby streetlamp was also not working and was unlit. Had the pedestrian island and streetlamp been illuminated it may have helped the driver to see Mr Easdale earlier and avoid the collision.</p> <p>Conclusion of the Coroner as to the death:</p> <p>Road Traffic Collision</p>

4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>At the inquest I heard evidence from two police officers ██████████ of the Bedfordshire, Cambridgeshire and Hertfordshire (BCH) Serious Collision Investigation Unit. They outlined that approximately 15 metres from where Mr Easdale crossed the road, there was a traffic island (or pedestrian refuge) with a bollard and streetlamp in place. The bollard on the island is made out of opaque white plastic and is designed to be illuminated from within. The time of the collision was around 5pm on a December afternoon meaning that this stretch of road was in deep darkness.</p> <p>When the collision occurred on the 5th November 2021, neither the illuminated bollard nor the streetlamp were in working order and were therefore unlit. Both officers from the collision unit gave evidence that this situation presented a danger to road users and pedestrians.</p> <p>A Traffic Management Officer has brought this situation to the attention of Hertfordshire County Council, Highways England (now National Highways) and National Power Networks (now UK Power Networks).</p> <p>Despite this, I heard evidence at the inquest that both the bollard and the streetlamp have still not been repaired and remain unlit even in the hours of darkness.</p> <p>I was not able to say on the balance of probabilities that the lack of lighting on the pedestrian island contributed to Mr Easdale's death as he was not using the crossing itself when he was struck. He crossed nearby, however, and it is possible that had there been illumination at that island the driver of the car would have seen him earlier and potentially avoided the collision.</p> <p>I am satisfied that the lack of working lights at this location on the B197 Digswell Hill poses a danger to road users and pedestrians. The location of the island is near to the Red Lion Public House and may be used by people going to and from the pub.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>[BRIEF SUMMARY OF MATTERS OF CONCERN]</p> <p>(1) That the lack of working lights on the pedestrian refuge on the B197 Digswell Hill (near the Red Lion Public House) poses a danger to road users and pedestrians. Specifically that neither the illuminated bollard nor the streetlamp are in working order.</p> <p>(2)</p> <p>(3)</p> <p>(4)</p>

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you: [REDACTED] - Chief Executive of Hertfordshire County Council; [REDACTED] - Chief Executive of National Highways; [REDACTED] - UK Power Networks Holdings Ltd both individually and collectively have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 10th April 2023. I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <p>The family of Mr Steven Easdale.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Date: 13th February 2023</p> <p>Signature</p>  <p>Geoffrey Sullivan HM Senior Coroner for Hertfordshire</p>