REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF KAIUS JOHN PAUL TUTT

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]; Service Director – Connectivity and Environment
1	**CORONER** I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.
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 25 October 2022 I commenced an investigation into the death of Kaius. The investigation concluded at the end of the inquest on 27 April 2023. The conclusion of the inquest was as follows **Road Traffic Collision** The four questions - who, when, where and how – were answered as follows **Kaius John Paul TUTT died on 14 October 2022 on the A391 Between the SCREDDA and CARCLAZE roundabouts near St Austell Cornwall from trauma after Kaius attempted an overtaking manoeuvre whilst riding his motorcycle and collided with a car being driven on the opposite carriageway.** The medical cause of death was found as follows **1a) Multiple injuries** **Comment: There were head, aortic and pelvic injuries that were not compatible with life. Toxicology was negative.**
4	**CIRCUMSTANCES OF THE DEATH**

	Kaius died from injuries sustained after the motorcycle he was riding collided with a car coming in the opposite direction. At the point of the collision the motorcycle that Kaius was riding was in contravention of solid double white lines. The collision occurred at approximately 19:05 hours on Friday 14th October 2022, on the A391, St Austell, Cornwall. Kaius was approaching the Carclaze roundabout, riding his Honda 125cc motorcycle towards St Austell having come from the direction of the Scredda roundabout. The court found that rider error on the part of Kaius was the cause of the collision, contributed to by the faded road markings and a visibility issue at the collision location.
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) The deflection arrows on this stretch of road were found to have faded and to have almost entirely disappeared in places. (2) The court found that there were visibility issues for those travelling downhill viewing cars exiting roundabout and vice versa. (3) The court found that the overtaking opportunity at the collision location is of marginal benefit, given that there are other better overtaking opportunities on this stretch of road. (4) The court found that Cormac has made a recommendation to Cornwall Council that the road layout is amended to remove the downhill overtaking section at this location at the first reasonable opportunity, but that currently no funding is available to facilitate this recommendation.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, Cornwall Council, 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 18 July 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 Kaius' family. I have also sent a copy to [redacted] of Cormac 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	**22 May 2023** **Guy Davies** Assistant Coroner for Cornwall & Isles of Scilly