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:** Local Authority for East Riding of Yorkshire – Highways Department
1	**CORONER** Miss Lorraine Harris, Area Coroner, East Riding of Yorkshire and City of Kingston Upon Hull.
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 2nd August 20222 I commenced an investigation into the death of Richard Stephen LITTLEWOOD, aged 40 years. The investigation concluded at the end of the inquest on 26th June 2023. The conclusion of the inquest was Road Traffic Incident. Box 3 of the record of inquest read: *On 8th July 2022 Richard Stephen Littlewood was travelling on his motorcycle on the A1033. As he rounded a bend his motorcycle crossed the white line and he struck an oncoming vehicle. Mr Littlewood was conveyed to Hull Royal Infirmary with multiple traumatic injuries. He spent 3 weeks in intensive care but died on 29th July 2022, he was 40 years of age.* One of the findings of fact stated: *The Forensic Collision Investigator feels, and I agree, that it was likely rider error, braking on the bend caused the motorcycle to become upright and travel in a straight direction.* Mr Littlewood's medical cause of death was recorded as: **COD:** **1a** Bronchopneumonia **1b** Multiple traumatic injuries **1c** Road traffic incident

4	**CIRCUMSTANCES OF THE DEATH** Mr Littlewood was travelling on his motorcycle with a friend in convoy, he has braked when taking a bend in the road causing his motorcycle to travel in a straight line and into the path of an oncoming vehicle. He was conveyed to Hull Royal Infirmary with traumatic injuries. He died 3 weeks later 29th July 2022.
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) Evidence was heard that, on this particular stretch/bend of the A1033, there have been 3 incidents that have occurred within a short space of time. • A fatality leading to the death of Mr Littlewood in July 2022. • A fatality leading to the death of another male in November 2022. • An incident involving a farm vehicle which shed its load in late June/early July 2022 (very little details are known of this, suffice that it occurred near the location of the bend in the road where Mr Littlewood died, albeit on the opposite side). I do acknowledge that each of these incidents are completely different scenarios. It may be worthwhile to note that it is local road users that have been involved in all the incidents. (2) During evidence it was heard that signage and road markings have been discussed between the police and Highways that may make the road safer. Some signage had been put in place but an assessment needs to be completed for additional road markings and the timings for this were unclear. I am aware that after every fatality in this area the police and the Highways liaise with each other over signage/road markings as a matter of course. I have concerns only regarding the fact that no timescale had been set for the assessment to take place.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your department/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 22nd August 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 • The family of Richard Stephen LITTLEWOOD • Roads Policing for Humberside Police I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE]** **[SIGNED BY CORONER]** ***27th June 2023*** ***Lorraine Harris***