CORONER'S OFFICE
AREA OF HERTFORDSHIRE
The Old Courthouse, St Albans Road East, Hatfield, Hertfordshire, AL10 0ES

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. [redacted], Deputy Chief Executive, Executive Director of Resources, Hertfordshire County Council.**

1	**CORONER** I am Jacques Howell, assistant coroner, for the coroner area of Hertfordshire
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 21 July 2022 I commenced an investigation into the death of David Alistair Andrews, 63. The investigation concluded at the end of the inquest on 14 July 2023. The conclusion of the inquest was road traffic collision.
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. That on this particular stretch of road heavy goods vehicles are permitted to stop in order to unload, thereby effectively blocking the southbound carriageway.
4	**CIRCUMSTANCES OF THE DEATH** Mr Andrews was a keen cyclist and had been interested in cycling for about 10 years. On 11 July 2022, he was cycling south along the A4251, Tring Road, where he collided with a stationary heavy good vehicle which had stopped outside commercial premises waiting to unload. Sadly, he suffered significant traumatic injuries from which he did not recover, and he died on 12 July 2022 at St George's Hospital, London. The inquest received evidence that: • At the location where the road traffic collision occurred, the road is single carriageway road, with one lane serving each direction. The carriageway is 7 metres wide with each lane measuring approximately 3.1 metres in width with a

	double solid white line system with a gap between the lines of approximately 0.8 metres. Adjacent to the southbound lane is a grass verge, this gives way to an area of hard standing approximately 0.9 metres in width. A footpath is adjacent to the northbound lane. • The speed limit at this point is 40mph, there are no parking restrictions and it is not a designated clearway. • Photographs taken of the scene show that notwithstanding the heavy goods vehicle had stopped as far to the left as possible, the vehicle still took up nearly all of the southbound carriageway which bends to the right at this point. • Heavy goods vehicles frequently park on the southbound carriageway in order to unload, and witnesses have described this as "*…an accident waiting to happen.*" • Evidence was also received from the Forensic Collision Investigator, who gave evidence that in his view the current ability for heavy goods vehicles to lawfully stop outside the commercial premises to unload represents an ongoing risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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, namely by 18 October 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: 1. The family of Mr Andrews. 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	 **Mr. Jacques Howell** **Assistant Coroner for Hertfordshire** **1 August 2023**