REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sandwell Highways** **2. National Highways Agency**
1	**CORONER** I am Mrs Joanne Lees Area Coroner for the coroner area of the Black Country.
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. https://www.legislation.gov.uk/ukpga/2009/25/schedule/5 https://www.legislation.gov.uk/uksi/2013/1629/part/7
3	**INVESTIGATION and INQUEST** On 4/10/23 I commenced an investigation into the death of **PAUL ANDREW FREAR** aged 45 years who died on 22/9/23. The investigation concluded at the end of the inquest on 23/1/24. The conclusion of the inquest was Road Traffic Collision. The medical cause for the death of Mr Frear was 1a) Multiple Injuries 1b) Road Traffic Collision
4	**CIRCUMSTANCES OF THE DEATH** On 22/9/23 Mr Frear passed away at the Queen Elizabeth Hospital, Birmingham from injuries sustained in a road traffic collision on 21/9/23. The collision occurred on the A457 Tollhouse Way, Smethwick at the junction with the B4135 Rolfe Street. CCTV revealed that Mr Frear was a pedestrian waiting at a crossing area, when he entered the carriageway whilst the pedestrian lights were showing red and collided with a vehicle travelling in lane 2.
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. During the inquest I received evidence from the West Midlands Police Serious Collision Investigation Unit. Tollhouse Way is classified as the A457 and runs parallel to the B4169 High Street, Smethwick. Tollhouse Way is a dual carriageway and runs in a general north to south direction. The majority of the carriageway consists of two lanes in both directions and it is governed by a 40mph speed limit. The collision took place in the northbound carriageway at a set of traffic lights at the junction with the B4135 Rolfe Street where Mr Frear was waiting to cross the road as a pedestrian.
2. At the point of the collision the northbound carriageway separates in to three distinctive marked lanes. Lanes 1 and 2 are for traffic intending to continue straight on and lane 3 is for traffic intending to turn right in to Rolfe Street. On the day of and immediately preceding the collision, traffic in lane 3, immediately next to Mr Frear was stationary and held by a red filter traffic light situated directly above Mr Frear. However, traffic travelling in lanes 1 and 2 were able to continue straight ahead and were directed by a green traffic light.
3. Mr Frear entered the carriageway when the pedestrian control panel next to him was showing red indicating 'do not cross' and collided with a vehicle in lane 2 travelling correctly in accordance with a green light.
4. It is accepted that Mr Frear may have been distracted by using his mobile phone and/or influenced by pedestrians crossing from the opposite direction.
5. My concern is that the design of this junction means that it is not obvious to a pedestrian that the only place to look for left for indications as to whether it is safe to cross the road is to their left. There are no such indicators on the opposite side of the carriageway which is ordinarily where a pedestrian would be looking. The signals were situated immediately to the left of where Mr Frear was stood/where any pedestrian would be standing.
6. Within the police report the collision investigator (who visited the scene) states as follows; ***I do however find the layout very confusing with the right turn filter lane (lane 3) not being separated from the main carriageway a pedestrian is faced with stationary traffic. If a pedestrian chose to look up to their right they would be presented with a red traffic light and <u>the only indication that it is still not safe to cross is the pedestrian controls to their immediate left. The green light for lanes 1 and 2 is not visible to pedestrians and there is no pedestrian light indication on the opposite side.</u>'*** I share this concern.
7. Coroner understands from the police that there were two previous incidents at this location which occurred prior to the changes resulting in the current road layout. Coroner also understands Sandwell Highways

	have completed safety reviews and processes throughout the design, implementation and post installation of the junction design. 8. Whilst the current road layout may be legal, the death of Mr Frear highlights the safety issue for pedestrians present at this junction crossing from BOTH sides and highlights that the signage for pedestrians in not clear enough and there is a risk of further deaths now and in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion 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, namely by 1/4/24. 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 have also sent it to West Midlands Police Serious Collision Investigation Unit who may find it useful or of interest. 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	**26/1/24**  **Joanne Lees, Area Coroner for the Black Country**