


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. Staffordshire County Council
1	CORONER I am Nicholas Walker, assistant coroner, for the coroner area of Staffordshire and Stoke-on-Trent.
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 18 th December 2023 an investigation was commenced into the death of Kial Ryce Thurman. The investigation concluded at the end of the inquest on 2 nd August 2024. The conclusion of the inquest was that Kial Ryce Thurman died in a road traffic collision on 1 st December 2023.
4	CIRCUMSTANCES OF THE DEATH Kial was driving a transit van at speed along the A518 in the Lower Loxley area of Staffordshire heading in the direction of Uttoxeter when he lost control while navigating a right-hand bend immediately before a bridge that crossed the River Blythe. Either because Kial over-corrected his steering, or because the van hit the nearside kerb and rebounded, the van entered the opposing carriageway and into the path of an HGV. The impact caused the van to enter the river. Kial suffered multiple injuries and died at the scene.

5	<p><u>CORONER'S CONCERNS</u></p> <p>During 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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>The rural, unlit road is governed by the national speed limit of 60 mph and narrows in both directions at the point of the bridge. Driving towards Uttoxeter, drivers are faced with a right-hand bend that the inquest heard can catch drivers unawares and has been the location of other road traffic accidents. The inquest heard that the bridge has been repaired a number of times as a consequence of collisions. Although the road has signs that warn drivers of the nature of the hazard ahead, a police collision expert considered that a reduction in the speed limit at this location would reduce the risk of collisions.</p> <p>I am concerned that the national speed limit on the A518 at the point of the Blythe Bridge at Lower Loxley is too high and carries the risk of future deaths.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</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 8th October 2024 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: The family of Mr Thurman</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	<div></div> <p>Signed by the Coroner 13th August 2024</p>