REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF JAMES EDWARD TURNER

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Principal Transport Officer (Road Safety) Cornwall Council** **2. [redacted], Little Trethew, Horningtops, Liskeard, Cornwall**
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 1st August 2023 I commenced an investigation into the death of 49-year-old James Edward Turner. The investigation concluded at the end of the inquest on 2 September 2024. The medical cause of death was found as follows: *1a Head and Chest Injuries* The four questions - who, when, where and how – were answered as follows: *James Edward TURNER died on 25 July 2023 on the B3252 southeast of Liskeard Cornwall, from trauma when the motorbike he was riding collided with the offside of a twin axle trailer, laden with grain, that was being towed by a tractor across the B3252 from a field into the Fursdon Farm entrance opposite the field.* The conclusion of the inquest was as follows: *Road Traffic Collision*

4	**CIRCUMSTANCES OF THE DEATH** 1. James died whilst riding his KAWASAKI 1000cc motorcycle in a south-easterly direction on the B3252. 2. The B3252 at the point of the collision is a single carriageway and is subject to the national speed limit which is 60 miles per hour (mph) for the Kawasaki. 3. James collided with the offside of a twin axle trailer that was being towed by a tractor. The trailer was laden with grain and being towed across the B3252 from a field opposite the junction of Fursdon Farm. 4. The trailer had effectively blocked the road down which James had been riding. Forensic evidence indicated that James was braking until the moment before impact. James appears to have maintained the Kawasaki in an upright position whilst braking which implies rider input right up until the point of impact. 5. James was killed instantly, and his motorcycle caught fire shortly after impact. 6. The court found that James was riding at excessive speed in the period immediately before the collision and that it is likely that James' excessive speed has contributed to this collision. 7. The police conducted a visibility study using the same tractor and laden trailer involved in the collision together with an unmarked police motorcycle, which revealed the following: • The rider of the police motorcycle, when positioned towards the centre of the road, recognised something at the field entrance at a distance of 159.6m from the entrance, and was able to identify it as a tractor at 132.6m. • The tractor driver identified the motorcycle between 86.7m and 100.1m depending upon the motorcyclist's position within the width of the road. 86.7m when the rider was close to the road edge and 100.1m when he was nearer towards the centre hazard white line. • From a stationary position with the front of the tractor level with the entrance to the field, it took approximately 15 seconds for the tractor and trailer to emerge from the field and enter the farm entrance, completely clearing the road. 8. Calculations indicate that at a speed of up to 64mph, even with a response time of 2.5 seconds, James would still have been able to stop even if he only identified the tractor at the latest point when it could be identified as a tractor. 9. The court noted that at 60mph it would take 4 seconds for a road user to cover the 100m visibility that the tractor driver has at the centre hazard white line. On the basis of this study the court found that visibility at the site of the collision was limited for tractor drivers emerging from the field. 10. Furthermore, the court heard evidence of recent road traffic data that some motorists are speeding at that location. 11. Due to the concerns surrounding the poor view of the road from the field entrance, Cornwall Council recommended the following actions, which at the date of the Inquest had not been implemented. • Recommendation No1: Relocation of the field access opposite Fursdon

	Farm. This recommendation needs to be agreed with the landowner Mr Richard Harper. • Recommendation No2: Prescribed advanced warning signs to be provided at agreed location(s) on the B3252 to warn of '*Farm Traffic'*, replacing the temporary posters currently in situ. The Council indicated that this measure would be implemented as and when recommendation no1 is implemented.
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) Road safety at the location of the collision taking account of • the speed limit at the location, • the limited visibility for tractor drivers, • the nature of the tractor loads being conveyed at the collision site and the time it takes for combinations to cross the road, • the data that indicates some motorists are speeding at that location. (2) The fact that the recommendations made by the Council to improve road safety at the collision location have not been implemented.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 24 November 2024. 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 James' family. I have also sent it to Police Lead Investigator [redacted], and to [redacted] 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 and 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	**29 September 2024**  **Guy Davies** **HM Assistant Coroner**