John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Kingkabs Wheatsheaf Garage Parkgate Road Cheater CH1 6JS
1	**CORONER** I am John Adrian Gittins, Senior Coroner for North Wales (East and Central)
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 the 16th of October 2022 I commenced an investigation into the death of Andrew Howat (DOB 29.01.82 DOD 15.10.22). The investigation concluded at the end of the inquest on the 12th of November 2024. The cause of death was recorded as being due to 1(a) Multiple Injuries and the conclusion of the inquest was that the death was due to a road traffic collision
4	**CIRCUMSTANCES OF THE DEATH** On the 15th of December 2022, the deceased was collected by a Kingkabs taxi from a Chester Hotel. He was intoxicated at the time and as a result of disruptive behaviour the driver felt it unsafe to continue the journey and dropped him at a petrol station. Another taxi was ordered from the same firm, and he was collected for his onward journey home. Again as a result of his disruptive behaviour the driver was not prepared to continue the journey without full payment of the fare and stopped in a layby on the A483 dual carriageway in an unlit area with no means by which a pedestrian could easily leave the area (notwithstanding that there was a junction approximately 400 metres away which would have been a safe place to discharge the passenger). When the deceased got out of the taxi, the drive left him in an unsafe location and no contact was made with the police by the firm to advise them of the potential risk to both the deceased and other traffic.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed the following matter 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 **MATTER OF CONCERN** is as follows. – Oral testimony was given by a representative of Kingkabs that appropriate training was being provided to drivers seeking to balance the risk to themselves with their duty of care to their passengers, however the taxi driver stated in his evidence that if similar circumstances arose, he would do nothing different and would still be prepared to leave a passenger in an unsafe location.

	Furthermore, the firm's representative advised that usual practice would be to contact the police in circumstances such as these, but this was not done on this occasion and no evidence or documentation was available to corroborate that staff were being trained in respect of this protocol.
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 8th of January 2025 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 Family of the Deceased and to the Chief Coroner. 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	Dated 13th November 2024  Signature Senior Coroner for North Wales (East and Central)