REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST TOUCHING THE DEATH OF

NIGEL WILLIAM SWEET

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive Officer, National Highways
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 18 March 2024 I commenced an investigation into the death of 63 year old Nigel William Sweet. The investigation concluded at the end of the inquest on 19 December 2024. The medical cause of death was found as follows: *1a Multiple Injuries* *1b Road Traffic Collision*

	The four questions - who, when, where and how – were answered as follows: *Nigel William SWEET died on 7 March 2024 on the A38 between Trerulefoot and Tideford Cornwall from injuries sustained after he lost control of his motorcycle due to rider error whilst attempting to complete an overtake of another vehicle in wet conditions. The motorcycle fell onto its side as Nigel lost control. Nigel was separated from his motorcycle and he slid across the carriageway into the path of an oncoming vehicle which was unable to avoid him despite emergency braking and steering input. That oncoming vehicle drove over Nigel who suffered unsurvivable injuries as a consequence.* The conclusion of the inquest was as follows: *Road Traffic Collision*
4	**CIRCUMSTANCES OF THE DEATH** The reason for the collision was found to be rider error by Nigel, in wet road conditions whilst attempting an overtake in a creeper lane. A creeper lane is an additional lane, added to a single carriageway for a short stretch to allow for overtaking. There are a number on this stretch of the A38 which present road users with brief opportunities to overtake slower moving vehicles, before the road reverts to single carriageway on both sides. Nigel had overtaken at least one vehicle and was attempting to overtake a second vehicle by using the additional lane of the creeper lane. There was steady and oncoming traffic on the other carriageway. Nigel had insufficient space in the creeper lane to safely complete the overtaking manoeuvre of the second vehicle. Nigel lost control of his motorcycle whilst under braking at which time he was likely trying to get back into the single carriageway at the end of the creeper lane. In that sense the creeper lane contributed to the collision. The court found that there was nothing that the driver of the oncoming vehicle could have done to avoid Nigel.
5	**<u>CORONER'S CONCERNS</u>** 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) The court found that this stretch of the A38 from Carkeel roundabout to Trerulefoot roundabout has a history of a higher proportion of road traffic collisions compared to equivalent roads. This is because of the nature of the A38 over this stretch which features predominantly single carriageway layout with occasional creeper lanes. (2) The court heard evidence that a safety scheme had been developed to introduce average speed cameras for this stretch of the A38 but that funding had not yet been approved. The safety scheme was specifically designed to reduce the higher proportion of collisions on this stretch of road.
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 17 February 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 Chief Coroner and to the following Interested Persons, namely Nigel's family. I have also sent it to MPC [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. 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	**23 December 2024** **Guy Davies**