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. Secretary of State for Transport** **2. Chief Executive of Essex County Council** **3. Director of Hatton Traffic Management** **4. Director of Affinity Water**
1	**CORONER** I am Sonia Hayes, Area Coroner, for the coroner area of Essex
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 12 December 2022, I commenced an investigation into the death of Paul Stephen COLLINGRIDGE, AGE 28. The investigation concluded at the end of the inquest on 3 October 2024 . The conclusion of the inquest was 1a Multiple Traumatic Injuries. Road Traffic Collision
4	**CIRCUMSTANCES OF THE DEATH** Paul Stephen Collingridge died on 6 December 2022 of Multiple Traumatic Injuries sustained when his motorcycle high sided on an unlit road in the hours of darkness following sudden braking on the approach to roadworks ejecting him into the path of oncoming traffic. Mr Collingridge was travelling on the Colchester bound single carriageway navigating a bend when there was queuing traffic and was struck by an oncoming vehicle that had no opportunity to take avoiding action on the B1027 Colchester Road at junction with Frowick Lane, St Osyth. The roadworks for utility repairs had been put in place overnight and the required permit was not in place.

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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) Where Road Works Permits are required by utility companies these are often urgent to carry out vital repairs. This can mean that roadworks are set up in hours of darkness and may cause difficulties calculating distances as set out in the Safety at Street Works Code of Practice.

(2) The Safety of Street Works Code of Practice sets out how to take measurements to set out street works that include utlising street furniture that are at set distances and standard road markings that have standard lengths on carriageways with specific road speeds.

a. Some carriageways do not have street furniture
b. Some of the road markings on the carriage where the fatal collision did not comply to standard lengths and therefore the markings can have variations.
c. The Code of Practice does not set out how to calculate the distance where there is road curvature where the road markings have differing lengths on opposing sides where the markings are delineated on bends in a carriageway.

(3) A road works warning sign was placed at the junction that joined the carriageway of a road that obscured visibility of traffic joining the main carriageway. Whilst this did not cause or contribute to this incident this was not in accordance with the Code of Practice.

(4) The fatal incident that occurred on 6 December 2022 was not notified on the retrospective permit application for roadworks on the following day. There is no requirement for a fatality within roadworks be notified on application for an application for a permit .

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 16 April 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: • Family I have also sent it to Essex Police who 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 by the Chief Coroner.
9	S. M. Hayes **20 February 2025** **HM Area Coroner for Essex Sonia Hayes**