# REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>**Secretray of Sate for Transport** |
| **1** | **CORONER**<br><br>I am Miss Louise PINDER, His Majesty's Senior Coroner for the coroner area of Rutland and North Leicestershire. |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 28 September 2023 I commenced an investigation into the death of Patricia Heidi BUSHELL aged 56. The investigation concluded at the end of the inquest on 14 May 2025. The conclusion of the inquest was that:<br><br>Mrs Bushell was a pillion passenger on a motorcycle being driven by her husband, when at just before 1.20pm on 9th September 2023 they were struck by a car which failed to stop at the junction on Stapleford Road and entered the carriageway of the A606. Mrs Bushell was thrown from the motorbike and came to rest on the road, sustaining fatal injuries. She was taken as an emergency to Queens Medical Centre Nottingham where she sadly died that same day. There were multiple missed opportunities to identify a significant risk to road users during a period of resurfacing work. At the time of the collision, there was no advanced warning of white line removal at the junction and the permanent "Give Way" sign was not visible. As a result, the driver of the car which struck Mrs Bushell had not identified the junction and failed to stop.<br><br>The cause of death was established as:<br><br>I a Chest and Abdominal Injuries<br>I b<br>I c<br><br>II |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>The driver of a car which struck the motorbike on which Mrs Bushell was travelling, did not identify the junction ahead and was given very little opportunity to do so. The words "SLOW" were painted on the road 70 metres prior to the junction. There were permanent centre white lines/warning lines painted on the road commencing approximately 60 metres from the junction. Neither of these hazard |

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| | warnings alerted the driver to the junction ahead. The topography gave the impression that the road continued ahead. A temporary sign with a red background and white writing displaying the words "No road markings at junction" was in situ at the junction and attached to the base of the permanent Give Way sign, this permanent sign was leaning over and obscured by foliage. The permanent white lines at the junction had all been removed including some of the centre/warning lines. There was inadequate signage on the road to assist the driver in identifying the approaching junction.<br><br>There is no evidence that the driver was distracted prior to the collision. He was using the Waze satellite navigation application on his phone and whilst I am not critical of its use or design, it contributed to the impression that there was no junction ahead.<br><br>There were multiple missed opportunities to identify that there was a significant risk to road users during a period of resurfacing work particularly from 4th September to 9th September 2023. Despite numerous dynamic risk assessments over these six days, it was not identified that the permanent Give Way sign was obscured by vegetation. No drive or walk through along the road had been conducted which would have afforded the four traffic marshals and their supervisor a drivers view of the junction and highlighted the associated risks.<br><br>A witness gave evidence on behalf of Leicestershire County Council (LCC) and accepted that they are responsible for the signage at this junction. LCC also accepted that there were missed opportunities to identify that the permanent Give Way sign was obscured. Reference was made to The Road Traffic Regulations and the Traffic Signs Manual and it remains the view of LCC that the single temporary sign in place on the road was appropriate and complied with the guidance.<br><br>It was accepted however that the processes that existed at the time of the collision required review and more robust and specific written risk assessments are now in place locally together with more comprehensive training for those involved in traffic management, using the circumstances of this collision as a learning and retraining exercise. Further suggestions made by the police in court including giving consideration to additional temporary warning signs well ahead of the junction, the introduction of a lower temporary speed limit and introduction of a drive or walk through of the approach to the area from a road users' perspective and these will be included in a new written risk assessment. |
| **5** | **CORONER'S CONCERNS**<br><br>During the course of the investigation my inquiries 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.<br><br>The **MATTERS OF CONCERN** are as follows:<br><br>I indicated at the conclusion of the inquest that I will not be making a report in respect of the missed opportunities identified in relation to Leicestershire County Council employees. Significant changes have been made. I am however concerned that in respect of the national regulations, I am told that the temporary signage installed at the collision site was compliant with the guidance. Reference was made to The Road Traffic Regulations and the Traffic Signs Manual and it remains the view of LCC that the single temporary sign in place on the road was appropriate and complied with the guidance. It was nevertheless inadequate.<br><br>I refer specifically to Chapter 16 paragraph 20 of the Coroners Bench Book, "Where the identified risk to life has already been ameliorated by local changes the coroner may wish to consider whether the matter is an issue that only affects the relevant local organisation or is a wider or national issue. In the latter case then directing a report to a national, professional or regulatory body might enable them to also consider relevant changes that might protect lives." I conclude that this is potentially a |

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| | wider national issue and I am writing to you, as you have responsibility for ensuring the transport network is safe and I wish to highlight the issues raised during this investigation and at the inquest particularly in relation to the current regulations with regard to temporary signage. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by July 09, 2025. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br>Mrs Bushell's family<br>The driver's family<br>Leicestershire County Council<br><br>I have also sent it to:<br><br>Leicestershire Constabulary<br><br>who may find it useful or of interest.<br><br>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.<br><br>I may also send a copy of your response to any person who I believe may find it useful or of interest.<br><br>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.<br><br>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: 16/05/2025**<br><br>  <br>**Miss Louise PINDER**<br>**His Majesty's Senior Coroner for Rutland and North Leicestershire** |