Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Assistant Director of Highways and Transportation, Milton Keynes Council**
1	**CORONER** I am : Adam Smith, Assistant Coroner for Milton Keynes Civic Offices 1 Saxon Gate East Milton Keynes MK9 3EJ
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 24 February 2025, Dr Sean Cummings, Assistant Coroner, commenced an investigation into the death of John Charles HICKMOTT aged 63. The investigation concluded at the end of the inquest on 21 November 2025. My conclusion at the inquest was that Mr Hickmott died by road traffic collision. The medical cause of death was: 1(a) Multiple fractures and cardiogenic shock.
4	**CIRCUMSTANCES OF THE DEATH** On 19 February 2025, at around 19:15 hours, Mr Hickmott crossed the road (V11 Tongwell Street, Northfield, Milton Keynes) near to the Audi garage. There was a pedestrian footpath at either side of the road where he crossed and a pedestrian island in the middle of the road so that pedestrians could stop midway. The road at this point is a single carriageway road, with a 60mph limit. It was dark and the weather was dry, although the road was damp. A number of nearby streetlights, including one immediately above the site of the collision, were not working at the time. The nearest lit streetlights were 75m and 105m respectively in opposite directions from the site of the collision. Mr Hickmott stepped from the pedestrian island in front of a moving car. On the evidence, he was probably intoxicated at the time. He had been seen a few minutes earlier stumbling on the grass verge and into the road. He was struck by the car and died at the scene from the injuries he sustained. The driver of the vehicle that collided with Mr Hickmott was following all rules and regulations, including driving well below the speed limit. He was not impaired by drugs or alcohol. Mr Hickmott would only have become visible to him at the last moment. The driver reacted appropriately and took evasive action, but once Mr Hickmott stepped into the road, the collision was sadly unavoidable.

5	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) I received evidence from witnesses who had attended the scene of the collision soon afterwards or driven past shortly beforehand, commenting on how dark it was and how difficult it would have been to see a pedestrian. I also received evidence from a Highways Strategic Asset Manager at Milton Keynes City Council, together with documents, indicating that a number of streetlights on this stretch of road had previously been reported as not working. These included a streetlight almost immediately above where the collision with Mr Hickmott took place and other adjacent/nearby streetlights. Specifically, there had been reports on 6 October 2024 of three individual streetlights not working, then on 20 November 2024 a report of a block of five more streetlights not working. It was stated in the Council's enquiry document that, "Several lamps on both sides of V11 are permanently out between the two Northfield Drive turnings" and that, "This is making this already accident-prone stretch of road more dangerous as the turnings are very dark." According to the Council's procedure at the time, the block of five lights should have been repaired within 14 days of having been reported defective and the three individual lights within 28 days. These lights had not been repaired at the time of the collision involving Mr Hickmott, nor when the Forensic Collision Investigator undertook a reconstruction 21 days later (see below). The evidence from the Highways Strategic Asset Manager was that six of the streetlights were repaired on 19 March 2025 and two more on 16 April 2025. I received a Collision Investigation Report from a Forensic Collision Investigator at Thames Valley Police's Forensic Collision Investigation Unit. This included detailed evidence about conspicuity, and how Mr Hickmott would have been especially inconspicuous in the dark, in the absence of working streetlighting proximate to the incident. This evidence included photographs from a reconstruction undertaken at the site in hours of darkness 21 days after the incident. The streetlights were still not working at that time. This evidence was striking in demonstrating how a pedestrian would be almost invisible to a driver (even when one knows they are present and are looking for them) until the driver is within 20 - 30 metres of the pedestrian, at which point they would start to be illuminated by car headlights. The Council's Highways Strategic Asset Manager also stated that, following an inspection of the same stretch of road, undertaken on 19 November 2025 following questions received from me, six streetlights were found not to be working (not previously reported to the Council as faulty). This may suggest a more fundamental technical problem with the streetlights on this stretch of road. The evidence of the Highways Strategic Asset Manager was that the priorities and timescales for repairs of faulty streetlights were already, as at November 2024, set out in the Council's contract with its principal highway services contractor, as well as the Code of Practice for Highways Electrical Maintenance. Despite this, the faults reported on 6 October and 20 November 2024 were not repaired until 19 March and 16 April 2025. I am concerned at: 1) The timeliness of repairs being undertaken when streetlights are reported as not being lit; 2) The extent of monitoring of scheduled repairs to ensure timely repair; 3) The extent to which proactive inspections are undertaken by the Council to identify faulty streetlights, or blocks of lights, that may not have been reported to the Council.

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 January 26, 2026. 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: Mr Hickmott's next of kin who may find it useful or of interest. 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. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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	**DATE** **SIGNED BY ASSISTANT CORONER** 1 December 2025 [redacted]