REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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 Officer Anglian Water** **3 Chief Executive Officer Suffolk County Council** **4 Chief Executive Officer of Core Highways Group Ltd**
1	**CORONER** I am Nigel PARSLEY, HM Senior Coroner for the coroner area of Suffolk
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 03 November 2022 I commenced an investigation into the death of: - **Allan STEVENSON** aged **73.** The investigation concluded at the end of the inquest on **20 March 2026**. The conclusion of the inquest was: **Narrative Conclusion - Allan Stevenson died as a result of the injuries he received in a road traffic collision. His death was contributed to, by the temporary road layout.** The medical cause of death was confirmed as: **1a Massive Head Injuries** **1b Road Traffic Collision**
4	**CIRCUMSTANCES OF THE DEATH** **On Monday 24th October 2022 it was a clear day and road surfaces were dry.** **The cyclist, wearing high visibility clothing was cycling east, towards Felixstowe along High Street, Walton. Where the roundabout intersects High Street and Walton Hall Drive a temporary traffic management system had been installed earlier that day.** **The cyclist stopped at the traffic lights, where the cycle path merges with the pavement as indicated by the blue sign. This was alongside cars on the left hand lane, as the temporary lights were red.** **When the light turned green the cyclist and 3 cars proceeded in the left hand lane, to left hand side of the traffic island, where there was a temporary 6-10 sign instructing traffic to keep right. This was to direct traffic to the southside of the**

	roundabout to travel in an anti-clockwise direction. **The HGV driver pulled out of the building site turning east into High Street. The HGV and cyclist arrived at the entrance to the roundabout at the same time. The cyclist was in left hand lane, the HGV was in the right hand lane.** **The cyclist and HGV simultaneously followed the road layout guided by the road management cones. At the point that the HGV and cyclist entered the roundabout the cyclist positioned to the front left hand corner of the HGV. This has been identified as a "blind spot".** **The HGV was travelling through the junction at 12mph. Due to the close proximity of the cyclist to the front near side of the HGV he remained in the HGV's blind spot for the duration of the manoeuvre.** **As the cyclist and HGV exited the roundabout they were forced by the temporary traffic management system to remain in a single lane on the right hand side of the work area. This included vehicles having to use suspended cycle lane on the right hand side of the road.** **At the exit point of the roundabout the cyclist was still in very close proximity and slightly ahead of the HGV. This is where the road traffic collision occurred.**
5	**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 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: **The evidence heard that the original plan drawn up by the company providing the temporary traffic management system (Core Highways), was based on map coordinates (a grid reference) sent to them by Anglian Water. The subsequently produced traffic management plan required the partial closure of a roundabout and to prevent confusion of road users, in addition to statutory signs two special signs were part of the plan.** **When Core Highway Traffic Management Operative's attended the site of the roadworks they were informed by the Anglian Water personnel present that the plan was incorrect, with the planned works being on the opposite side of the road to that indicated on the plan. This meant that the plan had to be 'flipped' to be the mirror opposite of the original plan which led to the following: -** **1. The original plan had two of the four traffic islands at the entry to the roundabout taper coned off, so that traffic was forced to use the one lane only past the traffic island when entering the roundabout, with entry being controlled by a four-way traffic light system. However, the flipped plan required one of these traffic islands not to be coned off (to allow traffic to turn left if required), leaving traffic free to use the road lanes either side of the traffic island to enter the roundabout when the lights changed to green.** **2. A junior Traffic Management Officer on site clearly identified a problem was occurring at that traffic island and suggested that a 'cone taper' be put in place from the kerb to the traffic island, to only allow entry onto the roundabout from the right-hand lane. This was not undertaken, and in evidence it was heard that large vehicles would not have been able to turn left at the traffic island had the cone taper been in place.** **3. At the time of the incident a single 'keep right' 610 sign (blue circle with white arrow) was in place to instruct traffic to only use the right lane when going past the traffic**

	island (as directed on the original plan). **However, due to the left lane still being open, it was heard from a police Forensic Collision Investigator that the correct signage should have been both a keep left and keep right 610 sign in place, with a 'special' sign indicating that the left-hand lane was 'turn left only', with the right-hand sign indicating all other routes. Because of the flip from the original plan no such special signage had been envisaged and was therefore unavailable.** **Had the correct signage been in place the Forensic Collision Investigator stated there would have been a reduced likelihood of this road traffic collision occurring.** **4. It was heard that a Suffolk County Council Network Inspector conducted an inspection of the temporary management scheme and identified that four road narrows 'dog leg' signs were incorrect, so he raised a 4-hour defect notice (these signs were indicating that the road narrowed from the wrong direction as a result of the plan flip).** **The Network Inspector explained that even though he was onsite with staff from the company who laid out the scheme, he would not speak directly to them regarding any identified defect but would need to take this up directly with the customer (i.e Anglian Water). The inspector contacted the Anglian Water defect line on 4 occasions and left a voicemail message but received no reply.** **The Network Inspector acknowledged that the process for getting road signage changed was not a direct one. He would contact the original customer, who would then contact Core Highways to implement the changes. A planner would then need to alter the plan details, with a coordinator then instructing a Traffic Management Operative to attend to change the signage on site.** **The Network Inspector did say, that in this case if replacement road narrow signs been available on site he would have requested that they were changed immediately rather than issuing a defect notice. However, it was heard in earlier evidence that only the signage identified on the scheme plan would be loaded onto the vehicles going to the site, and that there was no requirement to carry any replacement/alternative signage to effect any immediate changes that were subsequently identified.** **5. The Network Inspector said that in the normal course of events he would not have sight of any of the plans for a temporary road traffic scheme. He said that Network Inspectors usually look at the scheme once it has been laid down at the site, and if that scheme as laid down complied with the requirements of the Red Book (Safety at Street Works and Road Works, A Code of Practice) then that was all that was required.** **In this case the Network Inspector stated that at no time was he made aware of the flipping of the original plan, and he had no knowledge that special signs had been required by the original plan. The Network Inspector had no idea that the cycle lanes approaching the roundabout had both been suspended (only one of these cycle lanes had a sign detailing the suspension).** **The above raises the following concerns: -** **1. I am concerned that what was agreed by witnesses to be a complex temporary road traffic plan, can be 'flipped' on the ground on the day it is installed without any identifiable process being in place to ensure the scheme is subsequently safe.** **The court heard that some schemes (such as a single carriage way scheme controlled by only two sets of traffic lights) were straight forward to flip if required, but that no additional or enhanced review system was in place when a complex scheme needed to be flipped at short notice.**

	2. I am concerned that there is no apparent safety escalation process, when as in this case a relatively junior Traffic Management Operative identifies a safety issue with a scheme once it has begun operations. **3. I am concerned that the correct 'special signage' that would have undoubtedly made this scheme safer, was not even considered in this case (as a direct result of the flipping of the original plan).** **I am further concerned that Network Inspectors have no power to declare a special sign (or the lack of a special sign) as a defect, as these signs fall outside the mandatory signage shown in the Red Book.** **As such, even if a Network Inspector identified what they believed to be a dangerous temporary traffic management scheme, any danger being caused by the lack of special signage (or caused by special signage on site that is incorrect), there is no mechanism available for a Network Inspector to issue a defect notice to raise their concern.** **4. I am concerned of that the only recourse for a Network Inspector to get temporary traffic management signage replaced, is an apparently protracted procedural route involving multiple individuals remote from the site, with the Network Inspector having limited or no contact with the Traffic Management Operatives at the site itself.** **I am further concerned that there is no requirement for spare signage to be carried on vehicles used for setting up the schemes, for obvious or frequently occurring errors identified on temporary road traffic schemes (such as in this case the road narrow signs being the wrong way around).** **5. I am concerned that there is no apparent system in place to inform Network Inspectors that a traffic scheme has been laid out, contrary to the original plan that was in place (as in this case when a plan has been flipped).** **As a result of the Network Inspector having no access to, or sight of the original plan, he was unaware that the original plan had been flipped, unaware of the suspension of the cycle lanes approaching the roundabout and unaware that the special signage deemed necessary in the original plan, was completely absent in the flipped scheme that was put in place.** **As such the Network Inspector's ability to check the safety of the flipped scheme was seriously compromised.** **6. I am concerned that the 'defect line' operated by Anglian Water was not answered or responded to on the day of this incident, adding unnecessary delay to the changes required to the scheme signage. It is acknowledged that the signage defect identified on the 24th October 2022 would not have affected the tragic outcome of this case, however that may not be the case in future incidents**
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 June 01, 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 **Family of Allan STEVENSON** **Health & Safety Executive** [redacted] 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: 6th April 2026** [redacted] **Nigel PARSLEY** **HM Senior Coroner for** **Suffolk**