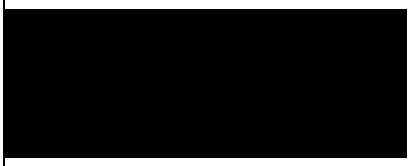
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REPORT TO PREVENT FUTURE DEATHS **REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013** Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).
1.	**CORONER** I am Nathanael Hartley, Assistant Coroner for the coroner area of Nottingham and Nottinghamshire.
2.	**DATE OF REPORT** 1 June 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. Cabinet Member for Transport and Environment at Nottinghamshire County Council 2. Head of District Highways Management, VIA – East Midlands You are under a duty to respond to this report within 56 days of the date of this report, namely by 28 July 2026. I, the coroner, may extend the period if an appropriate application is made
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

	The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN** Risk of death to those crossing between HMP Ranby prison estates on A620 Straight Mile in Ranby.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 26 March 2026 an inquest was opened into the death of Phillip Tetley, aged 42. The inquest concluded on 1 June 2026. I made a determination at inquest that he died from multiple injuries. The record of inquest recorded the following: Phillip Tetley died on 1 December 2025 at the A620 Straight Mile in Ranby from injuries received when he was struck by a vehicle whilst crossing the road. Conclusion: Road traffic collision.
9.	**CIRCUMSTANCES OF DEATH** Mr Tetley was employed at HMP Ranby and had parked in the overflow carpark on 1 December 2025 on his way in to work. HMP Ranby's main site is across the A620 Straight Mile, a 50mph road with no provision to assist those crossing between each site. Concerns had been raised by HMP Ranby in 2023 and traffic calming measures had been requested, but due to there being no recorded injury collisions at the location there was insufficient evidence to support the installation of such measures. Mr Tetley crossed the road into the path of an oncoming vehicle and was struck by it, and another vehicle, causing fatal injuries.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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 court heard evidence that the possibility of a crossing is being considered by the council. The overflow carpark to the south of the A620 has been increased in size and there is an increase in the number of people crossing the road to get to the prison estate. Many of those crossing expressed concern about crossing the road safely. The court is concerned that if nothing is done to assist those crossing the road there is a risk of future deaths. The court also received initial evidence from VIA in the form of a written statement that warning signs had been installed on the approach to the carpark, but then heard evidence that only "SLOW" signage had been installed, and planned "PEDESTRIANS IN THE ROAD/CROSSING" signage had not. As a result, drivers may be unaware of the risks posed at the car park location.

	SIGNATURE  **Nathanael Hartley** **HM Assistant Coroner** **For Nottingham and Nottinghamshire**