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 Lindsey TONKS, H M Assistant Coroner, for the coroner area of Staffordshire and Stoke-on-Trent.
2.	**DATE OF REPORT** 08 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. Staffordshire County Council 2. National Highways You are under a duty to respond to this report within 56 days of the date of this report, namely by August 02, 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**

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 19 January 2026 I commenced an investigation into the death of Charlotte Marie SAUNDERS aged 52. The investigation concluded at the end of the inquest on 03 June 2026. The conclusion of the inquest was 'Road Traffic Collision'
9.	**CIRCUMSTANCES OF DEATH** On the afternoon of 27 August 2024, Charlotte Marie Saunders was struck by a tipper lorry whilst attempting to cross Christchurch Way in Stone, Staffordshire. She sustained multiple injuries including a severe traumatic brain injury which resulted in prolonged disorder of consciousness, requiring 24-hour care for all her needs. Mrs Saunders' condition deteriorated on 25 December 2025 and she died in a specialist neurological care centre on 13 January 2026.
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 location of the road traffic collision involves a one-way carriageway, consisting of two lanes of traffic. This is a busy section of road that serves as a bypass around Stone town centre. At the section in question, there is a large supermarket on the outer part of the ring road and the main shopping area of Stone is located within the inner part of the ring road. There is a purpose-built pedestrian walkway leading from the supermarket car park to a bus stop, with metal pedestrian guardrails at the edge of the road to the north of the walkway preventing pedestrians from crossing the carriageway. There is no similar fencing to the south. On the inner side of that section of the ring road, there is an alleyway that leads directly into the town centre. There are metal pedestrian guardrails at the edge of the carriageway on that side also, running north from opposite the bus stop. Again, however, there is no similar fencing running to the south.

	There is a pedestrian crossing to either side of the collision location – one to the north and one to the south - each of which is traffic light controlled and each being said to be at a distance "within less than 100m" of Mrs Saunders' crossing point. Police inquiries revealed that Mrs Saunders had walked from the car park of Morrisons and had been attempting to cross the furthest lane carriageway, heading towards the town centre, at the time that she was struck. The Police Report stated that this route "is often used by pedestrians to cross over in to the town, rather than walking to one of the crossings". A police officer who gave evidence also described having visited the site for the purposes of his investigation and having observed at least ten pedestrians crossing at the same location during a period of no more than thirty minutes. I have concern that there is a risk of future deaths as a result of the current layout of this location, given the following: 1. The ring road is a busy road with heavy, consistent traffic flow, this being a bypass around the town centre 2. There is a busy supermarket with a large car park on one side of the ring road and the town centre on the other 3. There is a purpose-built pedestrian walkway leading to the pavement on the outer side of the carriageway and an alleyway leading directly into the town centre on the other side 4. There are no pedestrian guardrails either side of the carriageway at what appears to be a primary location used by people for their speed and convenience, to avoid the need to walk further to use the pedestrian crossings
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *[please do not use individual's names, but instead roles/titles]* • **Husband of deceased** • **Staffordshire Police** I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

12.	**SIGNATURE**  **Lindsey TONKS** **H M Assistant Coroner for** **Staffordshire and Stoke-on-Trent**