REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. Head of Highways of Bradford Metropolitan District Council** **2. Chief Executive of the Highways Agency**
1	**CORONER** I am Caroline Sarah Sumeray, Assistant Coroner, for the Coroner Area of West Yorkshire (West).
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 14th October 2012 I commenced an investigation into the death of Karl Olof Nilsson, aged 58. The investigation concluded at the end of the inquest on 27th September 2013. The conclusion of the inquest was Accident. The medical cause of death was found to be: 1a Multiple Injuries including Cardiac Tamponade and Flail Chest. 1b Road Traffic Accident.
4	**CIRCUMSTANCES OF THE DEATH** 1. The evidence in this case related to a road traffic collision that took place at around lunchtime on 14th October 2012 at the junction of the A657 Saltaire Road, and Victoria Road in Saltaire, near Shipley. The deceased was travelling on his motorcycle southbound on Victoria Road towards the junction of these two roads. Although the deceased was a Swedish national and was here in the UK visiting his family; he was familiar with the road on which he was travelling. He approached the junction at a speed of approximately 38 mph (as calculated by the Collision Investigator), which was slightly in excess of the speed limit of 30 mph. At the mouth of the junction (approached whilst travelling in a southerly direction) there is a STOP sign (a red octagonal sign on a yellow background),

	2. The deceased did not appear to see the junction until too late when a car driven by [redacted] which had stopped at the pelican crossing on the A657 Saltaire Road to allow pedestrians to cross, traversed slowly from west to east in front of him on the A657 Saltaire Road, causing Mr Nilsson to brake heavily before his motorcycle slid out from under him. The motorcycle crossed over the junction coming to rest on the other side, barely catching the rear of the car. Mr Nilsson was not so fortunate. He slammed into the side of the vehicle and suffered catastrophic injuries from which he died minutes later.
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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. There are a number of factors which could, in my opinion have caused or contributed to this fatality. Victoria Road is an absolutely straight road which is aligned in almost a perfect north-south direction. It is a wide avenue type of road, with large trees visible on both the east and west pavements. On both sides of the road there are parking bays, and the cars are able to park fully on the road, whilst still leaving ample room for cars to pass in both directions. The layout is the same on both sections of Victoria Road – both before and after it is bisected by the A657 Saltaire Road. There is a gradient of approximately 1:7 stretching uphill from north to south. The slope of the road is only interrupted by the A657, which is perfectly level, but due to the slope of the road, it is not seen until the driver is approximately 20 meters from the junction. Moreover, due to the slope of the road, the STOP sign and stop line painted on the road is only really visible when the driver is approximately 20 meters from the junction. The overall layout of the road (i.e. it being perfectly straight with a sort of symmetrical appearance on both sides) contrives to almost create an optical illusion. The driver's eye is drawn to the horizon in the centre – and as such, the STOP sign at the mouth of the junction is only in the driver's peripheral vision. 2. I am concerned that the overall layout of this junction was a substantial contributing factor to this fatal accident. 3. I am concerned that the STOP sign is not clearly visible in its current

	4. Furthermore, I understand from the evidence which was given to me that this is the **only** junction on the entire length of Victoria Road where the driver does not have right of way. It is possible that Mr Nilsson became confused as to where he was on Victoria Road. 5. I understand that since this fatal incident occurred, the Council has cut down the large tree next to the STOP sign at the junction, however it is my belief that the tree played no part in this accident. 6. The statistics presented to me during the course of the inquest that there have been 5 incidents where personal injury was caused at this junction in the last 3 years – Mr Nilsson's was the only fatality
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 27th January 2014. 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: [redacted] and [redacted] I have also sent it to Police Sergeant [redacted] who may find it useful or of interest. 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	 **H.M. Assistant Coroner – West Yorkshire (West) area.** **2nd December 2013**