ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Head of Dorset Highways Management, Dorset County Council, Dorchester**
1	**CORONER** I am STEPHEN NICHOLLS, assistant coroner, for the coroner area of Dorset
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 30th May 2013 Mr Sheriff Payne, Senior Coroner for Dorset opened the investigation into the death of DANIEL WARWICK JONES, date of birth 25/02/1990. The investigation concluded at the end of the inquest on the 22/01/2014 heard by Mr Stephen Nicholls. The conclusion of the inquest was the deceased died of multiple injuries in a road traffic collision.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had been riding a motorcycle on the A356 from the direction of South Perrott towards Maiden Newton. As he approached the junction with a side road Toller Lane leading to Toller Porcorum his motorcycle was in collision with a motorcar that was travelling in the same direction. The motorcar was turning right off the A356 into the junction leading to Toller Porcorum.
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. – The court heard evidence from the car driver and her passenger, a rider of another motorcycle who was out with the deceased, two further independent witnesses and finally the Police Officer who conducted the accident investigation. It became clear from a number of witnesses who used the road on a regular basis that they were aware that there was a junction at this point but were unaware of the roadside warning triangle sign to indicate a junction or of the white arrow painted on the road surface to direct traffic

	travelling in the same direction as the deceased to pull into the nearside carriageway. This road is subject to 60 mph speed limit. Consideration needs to be given to improving the signage at this junction. Either by marking double white lines on the A356 to tell users that they must not overtake or improving the size and position of warning triangles indicating there is a junction, or both of those improvements together with anything further that would prevent a further accident at this junction. Further whether the speed limit at or around junctions on this road need to be reduced. The Police Officer who is an experienced road traffic officer who has to provide accident reports to the Coroners and other Courts was of the view that the signage at all junctions along the A356 may need to be considered. The inquest of course only heard evidence in connection with this junction.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 30th March 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. 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	**3rd February 2014**