ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1.

Network Delivery & Development Directorate
The Higways Agency
Floor 9 The Cube
199 Wharfside Street
BIRMINGHAM
B1 1RN

1 CORONER

I am Anthony Frederick Curzon, assistant coroner, for the coroner area of Stoke-on-Trent & North Staffordshire.

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 19th February 2015 I commenced an investigation into the death of John Reginald Moreton aged 74 years. The investigation concluded at the end of the inquest on 4th November 2015. The conclusion of the inquest was that Mr Moreton died as a result of multiple injuries sustained in a road traffic collision.

4 CIRCUMSTANCES OF THE DEATH

The deceased a 74 year old male, was a keen walker and a member of a rambling club. On Sunday 15 February 2015 he left home alone intending to walk along a way-marked public footpath to visit a place of interest in the local area. At approximately 10.54am the deceased was on foot crossing over the A500 southbound dual carriageway half a mile prior to A34 Talke junction, Stoke on Trent. The deceased was involved in a collision with a red Kia Venga motor vehicle. He was conveyed by ambulance to the Royal Stoke University Hospital, Stoke-on-Trent where he died at 11.58am that day. A post mortem examination gave the cause of death as 1[a] multiple injuries.

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 collision occurred when the deceased attempted to cross the busy dual carriageway A500 at a point approximately one half mile from the A34 exit. This road links junction 16 of the M6 with Stoke-on-Trent and is generally in a southbound direction. The deceased had approached the edge of the dual carriageway after using a pedestrian's stile which led him directly to this point and where there is a gap in the central reservation to enable pedestrians to cross to the northbound carriageway and continue over another stile. There are no warning signs of the clear and present danger either for pedestrians or motorists on their approaches. The deceased was struck by a car and

would have died instantly.

The footpath has been in situ for many years prior to the construction of the A500 in the 1970s. I am not aware of any previous fatality but the danger is obvious with a road having the national speed limit.

Warning signs of pedestrians crossing are common elsewhere in the county. I am advocating they should be erected here. Another rambler was seen to cross this busy road whilst officers were still at the scene.

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 Friday 15th January 2016 to take account of the Christmas and New Year holiday seaoson. 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:-

(widow of the deceased)
 CMPG Regional CIU, Eastgate Street, Stafford, ST16 2DQ

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.

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