ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Street Lighting, Essex Highways, Essex County Council, County Hall, Chelmsford, Essex. CM1 1QH.**
1	**CORONER** I am Mrs Eleanor McGann, Area Coroner, for Essex
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 5th December 2014 I commenced an investigation into the death of Mr David John James Charles who was 44 years of age. The investigation concluded at the end of the inquest on 7th September 2015. The conclusion of the inquest was that Mr Charles dies as a result of a Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** On the 29th November 2014 Mr Charles was walking in the carriageway of Cranes Farm Road, Basildon in Essex whilst under the influence of alcohol. At approximately 1:00am he was struck by a motor car as a result of which he landed in the carriageway where he was struck by a second motor car. He died as a result of multiple injuries on the 29th November 2014.
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. – It was a dark and dry night. The section of Cranes Farm Road on which Mr Charles was walking when he was struck is provided with a system of street lighting. The lighting was switched off at the time of this incident. In the case of each driver, the evidence was that they could have done nothing to avoid the collision. This was due to the lack of ambient light and lack of expectation of seeing a pedestrian in the carriageway. If the street lights had been illuminated it would have improved Mr Charles's chance of being seen although this did not necessarily mean that either collision could have been avoided. It would, however, have given him a better chance of living.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 2nd November 2015. 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 • Admiral Insurance • [redacted] • Basildon Borough Council • Police • FCIU 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	**16th September 2015** **Mrs Eleanor McGann**