REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1.** [redacted]
1	**CORONER** I am Caroline Sarah Sumeray, Senior Coroner for the Coroner Area of the Isle of Wight.
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 26th May 2015 I commenced an investigation into the death of Jonathan Edward Hawes, aged 48. The investigation concluded at the end of the inquest on 17th December 2013. The conclusion of the inquest was Road Traffic Collision. The medical cause of death was found to be: 1a Multiple Injuries. 1b 1c 2
4	**CIRCUMSTANCES OF THE DEATH** 1) Jonathan Edward Hawes was born on 7th November 1966. At the time of his death, he was 48 years of age. 2) Mr Hawes was a very experienced motorcyclist, having ridden motorcycles for in excess of 30 years. 3) On 24th May 2015, he was riding with 2 friends in convoy, with Mr Hawes leading the group. They were travelling at a leisurely pace, between 20-30 mph on the A3055 Cowleaze Hill, Shanklin from the Ventnor direction. The road is a single lane carriageway in both directions, subject to the national speed limit, i.e. 60 mph.

	4) A white Renault Megane motor vehicle was travelling in the opposite direction being driven by a man, accompanied by his wife (in the front passenger seat) and 2 children in the rear of the vehicle. This vehicle was travelling below 30 mph. 5) The road twists and turns with bends in both directions and is subject to a degree of camber in places. As the car driver rounded a left-hand bend, there was a blind kink in the road to his right. He suddenly became aware of a motorcycle appearing from the other direction which was leaning heavily to its left side. The motorcycle dropped flat to the ground and slid across the carriageway slamming into the front of the car. 6) The car's airbags immediately inflated. The driver exited the vehicle and found the motorcyclist appeared to have died instantly in the collision with the front of his vehicle. 7) Assistance was provided from people living near to the scene of the collision, and paramedics arrived shortly after the incident, but they were unable to resuscitate Mr Hawes and pronounced him life extinct at 17.15 hours. 8) Examination of the vehicles involved revealed no defects, however it is likely that Mr Hawes was in 5th gear (out of 6), when the other experienced motorcyclists and Police witnesses suggested that a more appropriate gear to take that bend might be 2nd or 3rd gear.
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. During the course of the evidence, it became clear that whilst this stretch of road is subject to the national speed limit of 60 mph, all of the witnesses who gave evidence and who traverse the road regularly suggested that it would be dangerous to attempt to drive that stretch of road where there are blind bends and cambers, at 60 mph. 2. I am concerned that a reconsideration of the speed limit on Cowleaze Hill should be undertaken. 3. I am concerned that there are a failure to exhibit appropriate road signage and

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 19th January 2016. 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: the family of Jonathan Edward Hawes. 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. Senior Coroner – Isle of Wight** **24th November 2015**