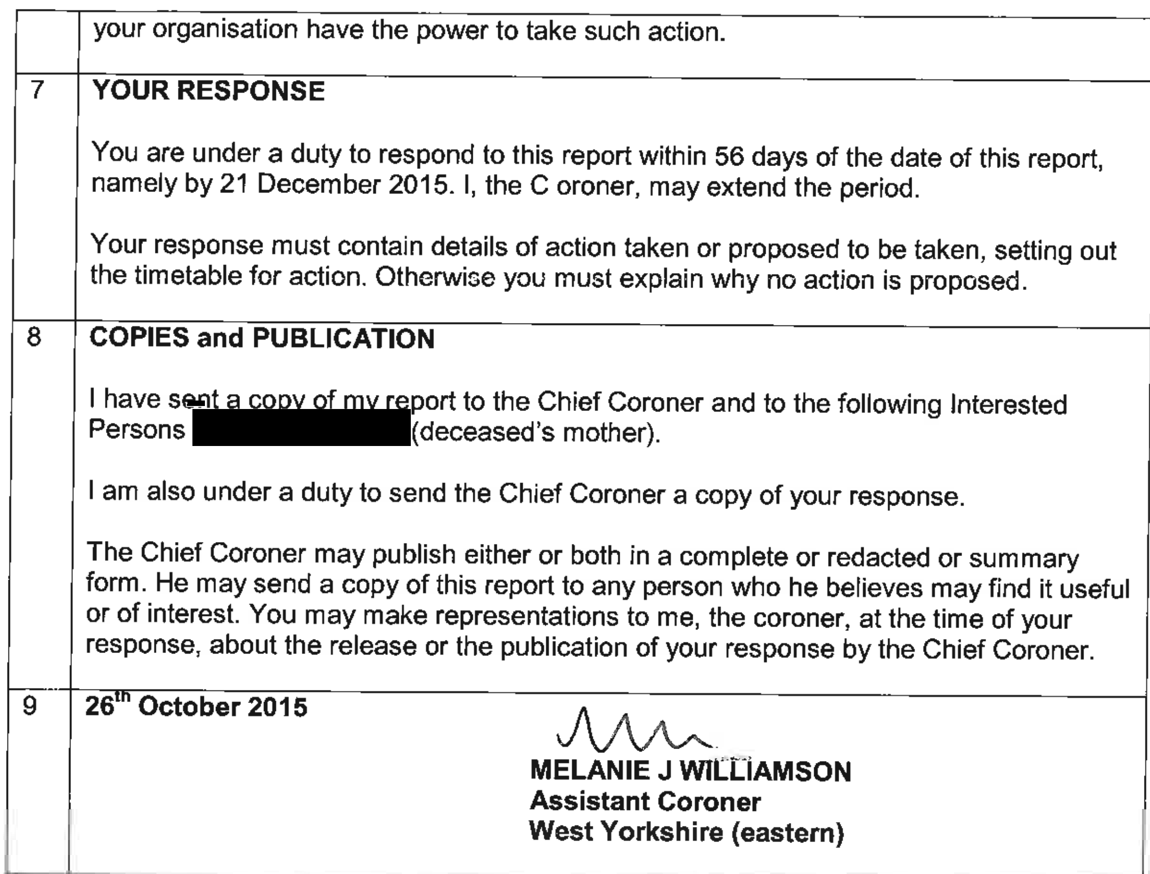
ANNEX A

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] 2. **Mr Jim O'Sullivan, Chief Executive, Highways England, Bridge House, 1 Wallnut Tree Close, Guildford, GU1 4LZ** 3. **Chief Coroner**
1	**CORONER** I am Melanie Jane Williamson, Assistant Coroner, for the coroner area of West Yorkshire (Eastern)
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 11th December 2014 I commenced an investigation into the death of Neil Layne Garry, aged 30 years. The investigation concluded at the end of the Inquest on 22nd September 2015. The conclusion of the Inquest was Accidental Death with the medical cause of death being:- 1(a) Traumatic brain injury.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 6.30pm on Wednesday the 10th December 2014, Neil Layne Garry was crossing the A6120 Ring Road in Seacroft in Leeds, in the proximity of Ramshead Approach. As he did so he was struck by a motor vehicle, as a result of which he sustained fatal head injuries. Neil was transported to The General Infirmary at Leeds where his death was certified at 0020 hours on the 11th December 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: – (1) There is no pedestrian crossing at, or in the vicinity of, Ramshead Approach in Leeds. The Ring Road (A6120) is a busy road in that particular area and is frequently navigated by pedestrians, especially by children, in the manner adopted by Neil Garry on the 10th December 2014.
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 21 December 2015. I, the C oroner, 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] (deceased's mother). 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	**26th October 2015** **MELANIE J WILLIAMSON** **Assistant Coroner** **West Yorkshire (eastern)**