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. Devon Highways Devon County Council Lucombe House County Hall Exeter EX2 4QD
1	CORONER
	I am John Geoffrey Tomalin, Deputy Coroner, for the coroner area of Exeter and Greater Devon.
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 15 July 2015 I commenced an investigation into the death of David Alan CURTIS. The investigation concluded at the end of the Inquest on 26 February 2016. The Conclusion of the Inquest was "Road Traffic Collision". Mr Curtis died from "moving blunt force trauma to the head and chest".
4	CIRCUMSTANCES OF THE DEATH
	Mr Curtis was riding his Suzuki motorcycle along the A3079 Holsworthy Road, Okehampton, Devon. The motorcycle was travelling north-westerly towards Thorndon Cross from Okehampton in the general direction of Halwill. The motorcycle collided with a John Deere tractor travelling in an easterly direction towards Foley Cross. The registration of the tractor is The weather conditions were good, the road was dry and in good condition.
	As the motorcycle crested the hill from the Okehampton direction, instead of negotiating the left hand bend at the top of that hill, it travelled straight on, colliding with the nearside front wheel of the tractor. The motorcycle and the rider finished up in the gateway to a field and lane entrance on the opposite side of the road.
	No mechanical defects were found with either the tractor or the motorcycle. The Police Forensic Collision Investigator concluded that the motorcycle was not travelling at a speed in excess of the national speed limit and, in any event, the left hand band, if the motorcyclist knew it was there, could have been negotiated at a speed above the national speed limit. The tractor had remained at all times in its correct carriageway.

There was nothing that the motorcyclist or the tractor driver could have done to avoid the collision once the motorcyclist had crossed into the opposite carriageway in front of the tractor.

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. -

When approaching from the Okehampton direction (the direction in which the motorcycle was travelling), there is a warning triangle sign advising motorists that they are approaching a 12% decrease in the gradient. There is no warning triangle indicating a left hand bend ahead. Conversely, when travelling from the opposite direction (Halwill towards Okehampton) there is a warning triangle indicating a right hand bend ahead and immediately below that there is another warning traffic sign indicating a slippery road. There was no prior signage warning vehicle users approaching the Halwill direction; the apparent course of the road ahead is denoted by the convergence of hedge lines towards the right.

Photographs taken of the road from Halwill towards Okehampton (the direction the motorcycle was travelling) show the crest of the hill but does not indicate that there is a left hand bend immediately beyond that crest until the driver or rider arrives at that crest. If it was deemed necessary to warn drivers travelling from Halwill towards Okehampton that there is a right hand bend ahead, which can be seen from some distance away in that particular carriageway, it would seem appropriate to consider that drivers travelling from Okehampton towards Halwill should have the benefit of a warning triangle sign indicating the left hand bend ahead, particularly where that bend cannot be seen until the hill is crested.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action and to consider the appropriateness of warning signs or otherwise to assist and guide drivers and riders of the presence of a left hand bend on cresting the hill on the A3079 Okehampton to Halwill carriageway, prior to the scene of this collision.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday 8th June 2016. I, the Deputy 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.

COPIES and PUBLICATION

I have sent a copy of my Report to the Chief Coroner and to the following Interested Person:

(Wife of the Deceased) 1.

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

Signed by Coroner John G. Tomalin, HM Deputy Coroner

Dated this 31st day of March 2016 (Sent 13.04.2016)