DAVID RIDLEY
Senior Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Associate Director, Highways & Transport, Wiltshire Council, County Hall, Bythesea Road, Trowbridge, Wiltshire, BA14 8JN.**
1	**CORONER** I am David Ridley, HM Senior Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 29th June 2016 I concluded the Inquest into the death of George Hedley Punton who died on the 3rd December 2015 at Southmead Hospital, Westbury-on-Trym, Bristol. An investigation was commenced by my colleague Coroner in Avon on 7th December 2015 and the conduct of the Investigation into his death was transferred to me following which I opened George's Inquest on the 16th December 2015 at which time upon being satisfied as regards identification I duly released his body back to his family following an examination after death. My conclusion at Inquest was that George had died as a result of road traffic collision which had occurred on the 21st of November 2015 in the village of Lockeridge, Wiltshire.
4	**CIRCUMSTANCES OF THE DEATH** • The road traffic incident involving George occurred at approximately 1044 on Saturday 21 November 2015; • George was a pedestrian who was walking his dog along the nearside of C38 in the village of Lockeridge, Wiltshire (OS grid ref 148677) more likely than not heading south. • George was struck by a Vauxhall Zafira travelling in the same direction through the village. The collision caused George to strike the nearside windscreen and "A" pillar of the Zafira which resulted in George sustaining a serious head injury. • The driver of the Zafira more likely than not was blinded by the sudden appearance of sunlight through a gap in the tree-line and as a consequence was not aware of George's presence on the nearside of the road. The exact point where the driver would have been affected by the sun is unclear but it more likely than not was approximately just short of 30m from the northern most give way markings at the junction with Ryles Lane. • The precise speed the Zafira was travelling was unknown but was not likely to have exceeded 25 mph at the time of the collision • As a result of the collision George was taken to Southmead Hospital, Westbury-on-Trym where he died as a result of his head injury on 3 December 2015.

5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows During the course of hearing evidence I heard from [redacted] who whilst not making any recommendations directly relating to the exact circumstances of George's death did indirectly highlight a concern relative to a nearby children's playground, the access to which from the village, which included the route George was on at the time highlighted the fact not unsurprisingly given the location that there were no pedestrian pavements. I think the simplest thing is for me to enclose with this report a copy of [redacted] report which highlights the location of the playground in question which lies to the north of the collision point involving George which took place at OS grid reference 148677. The similarity with the circumstances of George's death relate to the fact that George at the time was struck by the Zafira whilst walking on the highway due to the absence of any pavements. My initial reaction when reading [redacted] was that there could be many scenarios whereby villages due to their history in relation to highways may not be wide enough to accommodate pedestrian pavements but the location here of the playground and also regards its safe access by villagers including children does cause me concern. Whilst it is fair to say there have been no incidents in the previous four years I am sufficiently concerned so as to support [redacted] recommendation that motorists and other highway users ought to be alerted to the fact that there are no footways and that pedestrians are likely to be walking at the side of the road and as such I am satisfied that there is a risk that future deaths will occur unless action is taken and as such I was satisfied that my statutory duty to report those concerns has been triggered.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 25 August 2016. I, the Senior 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: [redacted] Counsel for Thrings Solicitors, representing the Family of Mr Punton DWF LLP, Solicitors representing [redacted] [redacted] Traffic Management Officer, Road Safety Unit, Wiltshire Police 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 Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated 1.7.16 Signature_____ HM Senior Coroner for Wiltshire and Swindon