Beverley Lawford John Siddall

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted], Corporate Director for Economy, Enterprise and Environment, Cornwall Council,** **1.**
1	**CORONER** I am Dr Carlyon the Senior Coroner for the area of Cornwall an the Isles of Scilly
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** **Beverley Siddall died on 8th August 2015 and an investigation was opened on 21st August 2015 and an Inquest on the 11th February 2016. The inquest hearing took place at Truro Municipal Buildings on 16th May 2016.**
4	**CIRCUMSTANCES OF THE DEATH** Beverley Siddall was driving his blue Fiat Panda car registration number [redacted] along the A3075 in the direction of Newquay on 7th August 2015. At around 22.40 pm, after a series of bends in the road at Perranwell, near Goonhavern, he failed to negotiate the last bend and his car left the road and dropped down four feet and entered a field, where the car was seen to bounce until it came to rest in a nearby river .He was not wearing a seat belt and the airbags deployed. As a result of this together with the collision, he suffered multiple injuries. He was attended by a first-aider and paramedics and transferred to the Royal Cornwall Hospital, Treliske, Truro where he was recognized dead at 03.09 on 8th August 2015 as a result of his injuries. It was not clear whether there was any reason why Mr Siddall failed to negotiate the bend.
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. – That two witnesses to the traffic collision noted in evidence that they had seen evidence of a good number of cars leave the A3075 road at Cosy Cottage, Perranwell at the same point as Mr Siddall. The police Collision Investigator at inquest, noted when he went to survey the scene there was another car present that had come off the road which had nothing to do with Mr Siddall's collision. There was concern at inquest that the road layout, or safety notices and/or barriers in place, were not adequate and that this section

	of road should be reviewed with the view to reducing the risk of cars leaving the road at this point.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation or arm's length company e.g. Cormac] have the power to take such action. To review this section of road to address the issue of car leaving the road at the end of the series of bends on the A2075 at Cosy cottage
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 July 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 [redacted]. I have also sent it to the Devon and Cornwall Serious Collison Investigation Unit who may find it useful or of interest. 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	**[DATE]** **[SIGNED BY CORONER]** **24.05.2016** Elizabeth Emma Carlyon