ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Highways Department** **Hampshire County Council** **The Castle** **Winchester SO23 8UJ**
1	**CORONER** I am David Clark Horsley, senior Coroner for the Coroner area of Portsmouth and South East Hampshire.
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 1st February 2016 I commenced an investigation into the death of Yogalakshmi Sinnaiah, aged 58. The investigation concluded at the end of the inquest on 7th July 2016. The conclusion of the inquest was: 1. Medical Cause of Death: Multiple injuries. 2. Circumstances of Death: At about 13.55 hours on 26th January 2016, Yogalakshmi Sinnaiah was struck by a lorry whilst crossing Dragon Street in Petersfield. She sustained injuries that were instantly fatal. 3. Coroner's Conclusion as to Death: Death due to an Accident.
4	**CIRCUMSTANCES OF THE DEATH** See 3 above.
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. Ms Sinnaiah crossed Dragon Street using the pelican crossing and I was told in evidence that she started to cross the road from the "wrong side" of the traffic light at the crossing, "cutting the corner". 2. I was also told in evidence that using the crossing in this manner is a common

	occurrence and that there have been a number of near misses of pedestrians in consequence. 3. It occurs to me that provision of railings at this crossing either side of the actual crossing would prevent this happening and would thereby reduce the potential for future incidents of the type involving Ms Sinnaiah.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 September 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: - Representatives of the deceased's family, - Hampshire Constabulary, Collision Investigation Unit and Road Policing Unit. 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	**25th July 2016** **SIGNED BY CORONER** **David Clark Horsley**