REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Cheshire East Council, Highways Department**
1	**CORONER** I am Janet Elizabeth Napier, assistant coroner, for the coroner area of Cheshire
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 21 July 2016 an investigation was commenced into the death of David Holman aged 38. The investigation concluded at the end of the inquest on 9 January 2017. The conclusion of the inquest was that David Holman died due to a road traffic collision.
4	**CIRCUMSTANCES OF THE DEATH** The deceased died instantly on 13 July 2016 when he rode his pedal cycle off the pavement bordering the A556 road at Plumley, into the path of a HGV vehicle travelling in the opposite direction. [redacted] was the collision investigator who gave evidence.
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. It appears that there is no cycle lane there and the road gets very busy, so the footpath was being ridden along. There is a road sign situated just after the area at which the descent into the road is thought to have taken place. One support of this goes into the footpath causing an obstruction. There is also a dip in the kerb edge there. No one seemed to know why it was situated there as there is no field entrance or other opening opposite it. It was thought possible that either one or the other or both of these things could have had some effect in the causation of him leaving the footpath. We should appreciate your consideration of these facts to see if any changes need to be made to less the chance of a similar occurrence happening.

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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 26 March 2017. 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 namely the family of the deceased. 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	**Dated: 30 January 2017** **Signed:**