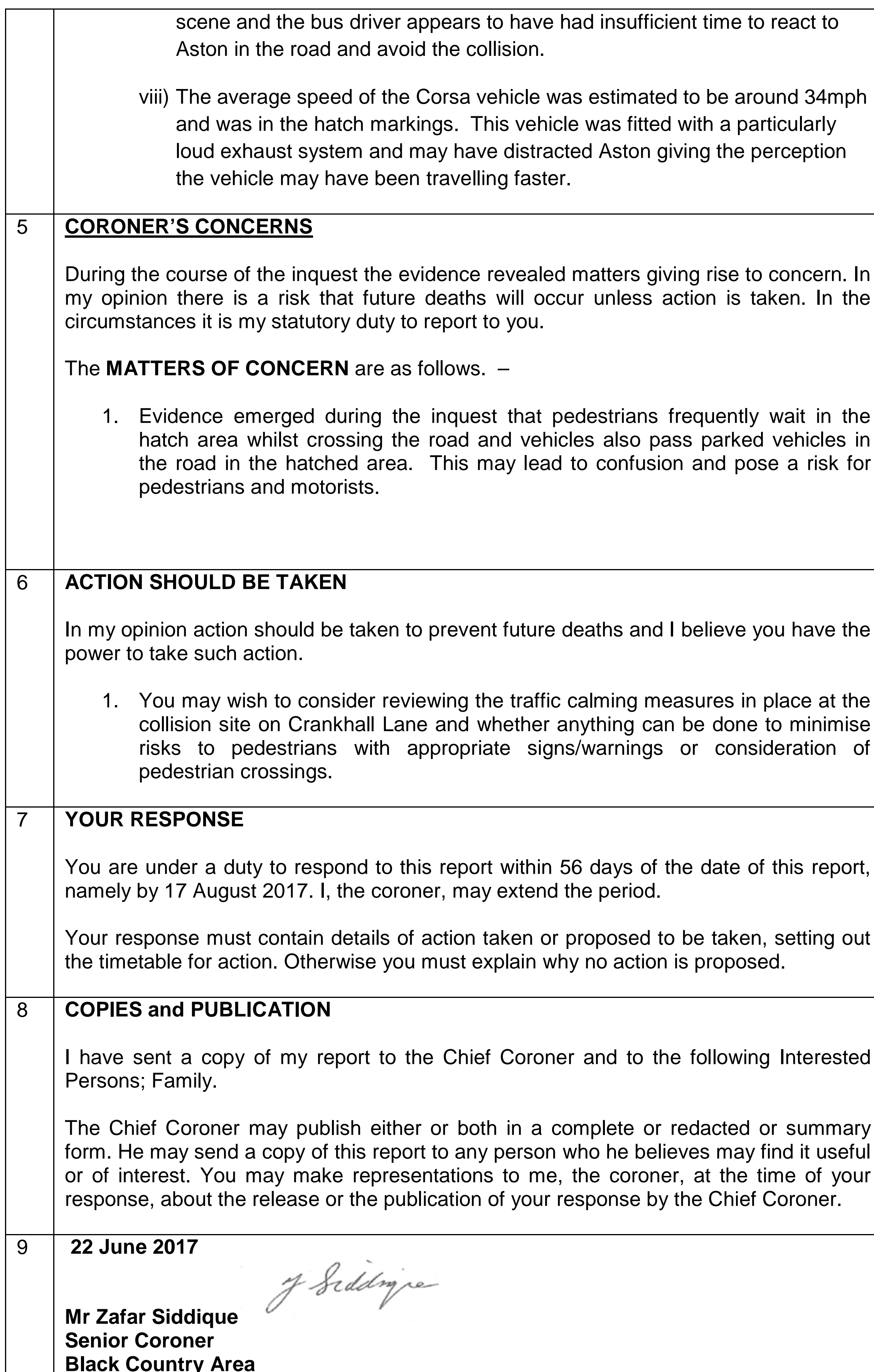
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Highways and Planning Department, Sandwell Local Authority.**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 16 November 2016, I commenced an investigation into the death of the child, Aston Soulsby. The investigation concluded at the end of the inquest on 26 May 2017. The conclusion of the inquest was a conclusion of: Road Traffic Collision. The cause of death was: 1a Hypoxic Brain Injury b Cardiac Arrest as a consequence of Road Traffic Collision
4	**CIRCUMSTANCES OF THE DEATH** i) At around 15:50 hours on the 1 November 2016 on Crankhall Lane, Wednesbury, schoolboy Aston Soulsby was involved in a collision with a bus. ii) The road in question is subject to a 30mph speed limit and at the time of the collision there were parked vehicles in the Walsall bound carriageway commencing from the island, and on West Bromwich bound carriageway they commence just after the collision point. iii) Between the two carriageways there is a central hatch marking area. iv) The bus was being driven along Crankhall Lane towards the general direction of West Bromwich and a second vehicle (Vauxhall Corsa) was being driven along the same road towards Walsall. v) Aston was in company with a group of school friends and were making their way home. One of his friends crossed the road but Aston who ran across the road narrowly missed the Vauxhall Corsa car but sadly was struck by the bus. vi) He sustained serious traumatic injuries and despite medical treatment he died on the 7 November 2016 in hospital. vii) The bus was travelling at a speed of 25mph on the approach to the collision



scene and the bus driver appears to have had insufficient time to react to Aston in the road and avoid the collision.

viii) The average speed of the Corsa vehicle was estimated to be around 34mph and was in the hatch markings. This vehicle was fitted with a particularly loud exhaust system and may have distracted Aston giving the perception the vehicle may have been travelling faster.

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. Evidence emerged during the inquest that pedestrians frequently wait in the hatch area whilst crossing the road and vehicles also pass parked vehicles in the road in the hatched area. This may lead to confusion and pose a risk for pedestrians and motorists.

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.

1. You may wish to consider reviewing the traffic calming measures in place at the collision site on Crankhall Lane and whether anything can be done to minimise risks to pedestrians with appropriate signs/warnings or consideration of pedestrian crossings.

7 **YOUR RESPONSE**

You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 August 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; Family.

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 **22 June 2017**

Mr Zafar Siddique
Senior Coroner
Black Country Area

[IL1: PROTECT]