ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Chief Officer for Highways Infrastructure, Development and Waste** **Lucombe House** **County Hall** **Topsham Road** **Exeter EX2 4QD**
1	**CORONER** I am John Geoffrey Tomalin, H.M. Deputy Coroner, for the coroner area of Exeter and Greater Devon.
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 23rd December 2016 I commenced an investigation into the death of Margaret Olive PINE (Mrs Pine), D.O.B. 5th July 1925, age 91. The investigation concluded on 24th August 2017. The conclusion of the inquest was that Mrs Pine died from the injuries she received as a result of a road traffic collision.
4	**CIRCUMSTANCES OF THE DEATH** On the 17th December 2016 Mrs Pine was the front seat passenger in a car driven by her friend [redacted] with another friend [redacted] in the rear of the car. All three ladies had been out for the evening to play bingo. They were returning from Westwood Ho, near Bideford, North Devon, to their homes in Barnstaple at approximately 9.30pm. The weather conditions were poor, it was raining, very misty and foggy. The driver of the car, [redacted], turned left at the Roundswell roundabout off the A39 with the intention of heading towards the Cedars roundabout between Sticklepath and Bickington near Barnstaple. This route would have taken her across two further roundabouts before turning right at the Cedars roundabout. In the fog, [redacted] became disorientated and made one wrong turn. Once she found her way back to the road linking the Roundswell roundabout with the Cedars roundabout she then proceeded but instead of turning right at the Cedars roundabout she turned right at the roundabout immediately before the Cedars roundabout. Continuing down this road without turning left into a residential development the road is closed off by a wall with which [redacted] collided. Next to the wall is a cycle path and a footpath but that is not wide enough for a car to travel down. The police that attended the scene described the visibility as very poor and that they were almost adjacent to [redacted] car when they found her vehicle. During the course of the Inquest it was identified that the entrance to this road from the roundabout does not have any sign advising drivers that this is a dead end, nor indeed does the wall blocking off the road have any form of warning reflective strips to identify this being a no through road.

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. – To avoid the potential for a similar incident in the future I would ask Devon Highways to consider the erection of signs at the start of the aforementioned road advising drivers that this was a no through road and at the end of the road which is closed off with a wall, affixing to that wall some form of reflective signage warning drivers they have reached the end of the road.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 20th November 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: **The family of Mrs Pine** [redacted] I have also sent it to The Devon and Cornwall Constabulary 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]** 21st September 2017 **[SIGNED BY CORONER]**