David C. Horsley LLB, Solicitor Her Majesty's Coroner for Portsmouth and South East Hampshire



The Coroner's Court 1 Guildhall Square Portsmouth PO1 2GJ

Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used after an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Director of Regeneration Portsmouth City Council Civic Office Guildhall Square Portsmouth Hampshire PO1 2AS

1 CORONER

I am David Clark HORSLEY, Senior Coroner for the 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 08/06/2017 I commenced an investigation into the death of Timothy Kevin ATKINS aged 48. The investigation concluded at the end of the inquest on 26/10/2017. The conclusion of the inquest was:

Mr ATKINS Medical cause of death was 1a Severe head injuries.

I concluded that the death was due to an Accident.

4 CIRCUMSTANCES OF THE DEATH

At about 17:28 hours on the Second June 2017 Timothy Kevin ATKINS was riding his bicycle on the shared cycle/pedestrian pavement on the A2030, Eastern Road, Portsmouth, when he was in collision with another cyclist riding in the opposite direction. As a result, he fell into the carriageway striking the rear nearside corner of a passing motor vehicle and sustained severe and unsurvivable head injuries. He was pronounced deceased by the attending paramedics at 17:56 hours the same day.

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 CONCERNS are as follows:

David C. Horsley LLB, Solicitor Her Majesty's Coroner for Portsmouth and South East Hampshire



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The corner of the shared cycle/pedestrian pavement where the cyclists collided is a narrow pinch-point with poor visibility and no safety barrier. I am of the opinion that the highway authority should give consideration to improving cyclist and pedestrian safety at this corner.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe the Council as the highway authority for the Eastern road 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 04 January 2018. 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 next of kin and the control of the Chief Coroner and to the following Interested Persons next of kin and the control of the Chief Coroner and to the following Interested Persons next of the Chief Coroner and to the following Interested Persons next of the Chief Coroner and to the following Interested Persons next of the Chief Coroner and to the following Interested Persons next of the Chief Coroner and to the following Interested Persons next of the Chief Coroner and to the following Interested Persons next of the Chief Coroner and to the following Interested Persons next of the Chief Coroner and the Chi

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.

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David Shad Hoperey

David Clark HORSLEY
Senior Coroner for
Portsmouth and South East Hampshire
Dated: 09/11/2017