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. **Highways Department** **Bath and North East Somerset**
1	**CORONER** I am Maria Voisin, Senior Coroner, for the area of Avon.
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 15th August 2017 I commenced an investigation into the death of **Jonathan Philip Armstrong SHAW**, Aged **44**. The investigation concluded at the end of the inquest on 23rd November 2017. The medical cause of death was: Ia) Multiple injuries The conclusion of the inquest was **Road Traffic Collision**
4	**CIRCUMSTANCES OF THE DEATH** On 4th August 2017 at around 08:45hrs. Jonathan Shaw was driving his Mini from Chew Magna on the B3130. Whilst negotiating a bend he lost control of his car and it crossed into the opposite side of the carriageway. Another vehicle was travelling in the opposite direction. The Mini collided with the front of this other vehicle. Mr. Shaw died at the scene due to his injuries
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. – At the inquest [redacted] from the Collision Investigation Unit gave evidence. He said that he had been made aware of a couple of incidents at the same location previously. I was also made aware by the family at the inquest of at least 3 or 4 incidents at this same location. [redacted] confirmed that he spoke with the Highways Department at Bath and North East Somerset regarding the location of the incident and his findings. He indicated that it was your intention to highlight the need to reduce speed for the bend by adding road signs with a suggestion of a maximum speed for the bend. In addition that you were going to add "slow" painted markings on both approaches to the location of this tragic incident. [redacted] confirmed that the day before the inquest he had travelled the road in question and that the changes had not been carried out.

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.
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 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 – the family and AXA Insurance (insurers of [redacted]. 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	**23rd November 2017** **M. E. Voisin**