




## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p>1. The Chief Executive, Wigan Council, Wigan Life Centre, The Wiend, Wigan WN1 1YN</p>
1	<p><b>CORONER</b></p> <p>I am M Jennifer Leeming, HM Senior Coroner for the Coroner Area of Manchester West.</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On the 9<sup>th</sup> of February 2017 I commenced an investigation into the death of Cameron Chadwick, 15 years, born 28<sup>th</sup> January 2002. The investigation concluded at the end of the Inquest on 5<sup>th</sup> July 2017.</p> <p>The medical cause of death was:-</p> <p>Ia Multiple Injuries</p> <p>The conclusion of the Inquest was Cameron Chadwick died of a Road Traffic Accident.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>On the 7<sup>th</sup> of February 2017 Cameron Chadwick was riding a motorcycle on Helveyllyn Road, Wigan when he lost control of the vehicle and fell from it, sustaining injuries that led to his death.</p>
5	<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows:</p> <p>1. During the Inquest evidence was heard that:-</p> <p>i. Evidence was given at the Inquest that there was a pothole in the carriageway near to where the accident that caused Cameron Chadwick's</p>

	<p>death occurred. An officer of Wigan Council informed the Court that a pothole that was 40mm or more deep should be repaired. A Police Officer gave evidence that whilst he could not fully guarantee the exactness of his measurement the pothole was 45mm deep at the time of this accident.</p>		
<b>6</b>	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion urgent action should be taken to prevent future deaths and I believe that you have the power to take such action.</p>		
<b>7</b>	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 31<sup>st</sup> August 2017. I, the Coroner, may extend the period.</p> <p>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.</p>		
<b>8</b>	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-</p> <ol style="list-style-type: none"> <li>1. [REDACTED] (mother), [REDACTED]</li> <li>2. [REDACTED] (father) [REDACTED]</li> </ol> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form.</p> <p>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.</p>		
<b>9</b>	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><b>Dated</b></p> <p><b>6<sup>th</sup> July 2017</b></p> </td> <td style="width: 50%; vertical-align: top;"> <p><b>Signed</b></p> <p></p> <p><b>M Jennifer Leeming, HM Senior Coroner</b></p> </td> </tr> </table>	<p><b>Dated</b></p> <p><b>6<sup>th</sup> July 2017</b></p>	<p><b>Signed</b></p> <p></p> <p><b>M Jennifer Leeming, HM Senior Coroner</b></p>
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