

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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	THIS REPORT IS BEING SENT TO:
	1. Highways England, National Traffic Operations Centre 3 Ridgeway, Quinton Business Park, Birmingham, B32 1AF, United Kingdom
1	2, A50 DBFO Major Projects Balfour Beatty Route Manager
	I am RACHEL SYED, Assistant Coroner, for the Coroner area of DERBY & DERBYSHIRE
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 28 February 2017, an Inquest was opened into the death of ADITYA PURI which was concluded on Thursday, 09 August 2018 by way of a Narrative conclusion. The medical cause of death being
	1a. Traumatic skull and brain injuries
4	1b. Road traffic collision. CIRCUMSTANCES OF THE DEATH ARE AS FOLLOWS
•	On the 23 February 2017, the deceased was travelling on the A50 Eastbound Findern, between junctions 3 and 4 when he lost control of his vehicle and collided with a stationary lorry which was parked in a layby. The collision was unwitnessed and it is not possible to determine what caused the deceased to lose control of his vehicle. The deceased was pronounced dead on the same day, following unsurvivable injuries he sustained from the collision.
	During proceedings, evidence was heard that there have been 4 additional fatal road traffic collisions on the A50 between junction 3 and 4, Eastbound and Westbound from 2017 to 2018.
	Whilst the lack of street lighting played no role in this collision, it would be beneficial for this stretch of the A50 to have street lighting, in light of the fact that there have been 4 further fatalities in a short period of time.
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 could 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) The A50 in question does not have street lighting. Street lighting in this area would be beneficial to prevent future deaths occurring. 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 04 October 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. **COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons The bereaved family **Derbyshire Constabulary** 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 09 August 2018 Rubel Sjed Rachel Syed, Assistant Coroner for Derby and Derbyshire