



**M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon**

24th August 2018

REF: 8564

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>Transport Department Bristol City Council</p>
1	<p>CORONER</p> <p>I am M E Voisin Senior Coroner for Area of Avon</p>
2	<p>CORONER'S LEGAL POWERS</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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 14/12/2017 I commenced an investigation into the death of Jacqueline Dympna JORDAN. The investigation concluded at the end of the inquest. The conclusion of the inquest was: Road Traffic Collision</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mrs Jordan died on 18th November 2017 at Passage Road, Brentry, Bristol. At around 6pm she had walked across the dual carriageway and central reservation which was a shortcut known to be used by pedestrians but which was not a designated crossing. She was struck by a car as she stepped into the path of the car, she was pronounced dead at the scene.</p>
5	<p><u>CORONER'S CONCERNS</u></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 MATTERS OF CONCERN are as follows:</p> <p>I was told by the police officer and the family that a barrier exists throughout part of the central reservation along this dual carriageway but is absent throughout this short stretch. If there was a barrier</p>

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	throughout this central reservation that it would potentially deter certain members of the public using this shortcut. I was told that there are 2 pedestrian crossings nearby
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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.
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7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 23 rd October. 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.
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8	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following interested persons – family of the deceased. 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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9	24/08/2018 Signature  M E Voisin Senior Coroner Area of Avon
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