HM Senior Coroner
for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]. Director of Highways & Transport Wiltshire Council County Hall Trowbridge BA14 8JJ
1	**CORONER** I am David Ridley, Senior Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 4 January 2018 I commenced an investigation into the death of Nana Kwabena Boansi BOATENG and an Inquest into his death was opened by me on the 12 January 2018. On the 9 August 2018 I concluded Nana's Inquest. I found that the medical cause of death was **1a) Chest Trauma with Haemorrhage 1b) Road Traffic Collision.** In box 3 of the Record of Inquest I recorded how, when and where Nana came by his death as follows:- Nana was confirmed as having died at the scene at 0425 on 24 December 2017 as a result of having sustained a chest trauma with haemorrhage when his Ford Fiesta motor car collided with a DAF Light Goods Vehicle travelling in the opposite direction on a left-hand bend on the A429 heading south towards Lower Stanton St Quintin in Wiltshire (OS ref ST 911 817). It is unclear as to why Nana had been on the opposite side of the highway (restricted by worn road markings) and he was attempting to return to the correct side of the highway when the collision occurred. Nana had been drinking alcohol (96mg/dl blood alcohol) prior to the incident and this more likely than not was a contributory factor in the collision occurring. Consistent with what I recorded elsewhere on the Record of Inquest as a conclusion I recorded – **Road Traffic Collision.**
4	**CIRCUMSTANCES OF THE DEATH** See box 3 above
5	**CORONER'S CONCERNS** During the course of the inquest the evidence I had been provided with a copy of a collision investigation report prepared by [redacted] of Wiltshire Constabulary. In the report I had regard to a number of photographs but in particular I noted a photograph that appeared on page 29 of 39 of his report which showed the approach to the left hand bend where the incident took place at night. As part of any road traffic Inquest I use Google Earth and in particular the "street view" function in order to get a feel for the location where the incident took place. I have

	included with this report three additional pictures of the location that have been lifted from Google Earth. The imagery was as at May 2017 according to the web browser which of course was some seven months prior to Nana's death. The photographs show the northern approach to the left-hand bend which is exactly the same path that Nana would have been travelling on that Christmas Eve morning. Whilst the state of the road surface appears to be in good condition what is not in good condition are the road markings. It is clear from the first picture that this section of road being a sharp left-hand bend travelling south is subject to no overtaking restrictions in both directions. Looking at the photographs the white lines that should be present in the centre of the highway have been significantly worn away to the extent that immediately approaching the left-hand bend they are non-existent. I was informed and as can be seen from the photograph in the police collision report, the cats eyes are also not in working condition. I appreciate that one should drive at a speed relative to the road conditions but in this instance, it is clear from the photographs that the road markings effectively suddenly disappear as a result of road wear. Whilst I was not able to make a finding on a balance of probabilities that the absence and the poor state of these central road markings more likely than not contributed to Nana losing positional awareness on the highway and crossing onto the opposite side of the highway where upon a collision then ensued as he attempted to return to his side of the highway, it does remain a possibility hence this report. I am sure you will appreciate road markings provide not only guidance to road users so that they can position their vehicle accordingly on the public highway but also serve to provide information to road users, as in this case, that this section of highway was subject to no overtaking in both directions. I would ask in view of this report that you urgently review this section of highway as its current state in terms of road markings is of great concern to me.

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 13 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Person, sister of Nana Boateng. 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	Dated 13 August 2018 Signature_____ Assistant Coroner for Wiltshire & Swindon On behalf of David Ridley, Senior Coroner for Wiltshire & Swindon