	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **James Bailey Commissioner for Highways and the Built County** **Highways Department** **Staffordshire County Council** **1Staffordshire Place** **Stafford ST16 2LP**
1	**CORONER** I am Mr Andrew Haigh senior coroner for the coroner area of Staffordshire South
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 30 May 2018 I commenced an investigation into the death of **Kendall James Chadwick aged 45 years.** The investigation concluded at the end of the inquest on **8 November 2018.** The conclusion of the inquest was accidental death with the medical cause of death being fracture of the base of skull.
4	**CIRCUMSTANCES OF THE DEATH** **Mr Chadwick died at the scene of a road traffic collision on the A518 at Lower Loxley on 24th May 2018. He had been riding a motorcycle and made an unsafe overtaking manoeuvre near a bend. He lost control of the bike and crashed off the road sustaining a fatal head injury.**
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 **MATTER OF CONCERN** is as follows. –**The location is the bend close to the Leese Hill. I am aware of at least one other fatality at the site. There is a sign for the bend, a slow sign in the road for the bend and chevrons and marker posts at the bend. The police have not expressed any particular concerns about the safety of the bend. I should however be grateful if you could have look at the bend to see if any additional steps would be advisable –such as an illuminated sign or rumble strips. At the time of the collision the chevron boards were in a dirty condition and there may be issues about maintenance here as well.**

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 10.1.2018**. 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 Mr Chadwick's family. I have also sent it to Staffordshire Police who may find it useful or of interest. **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	**15th November 2018** ..... Andrew A Haigh HM Senior Coroner for Staffordshire (South) Coroner's Office No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 sscor@staffordshire.gov.uk