## **ANNEX A**

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	1. London Borough of Lewisham
1	CORONER
	I am Philip Barlow, assistant coroner, for the coroner area of Inner South London
2	CORONER'S LEGAL POWERS
TI T	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 September 2017 I commenced an investigation into the death of Paul Fairey, age 44. The investigation concluded at the end of the inquest on 20 December 2018. The conclusion of the inquest was Road Traffic Collision. The Medical Cause of Death was 1a) Brainstem herniation 1b) Head injury.
4	CIRCUMSTANCES OF THE DEATH
TATALON TO THE TATALO	<ol> <li>Paul Fairey was a pedestrian on Mayow Rd, SE26. At about 00.40 on 23 September 2017 he walked into the northbound carriageway and was hit by a car travelling north. Mr Fairey suffered a severe head injury from which he later died.</li> <li>The collision occurred 500m south of Perry Vale between the junctions of Adamsrill Rd and De Frene Rd, near a pedestrian crossing point and to the entrance of Mayow Park.</li> <li>The evidence at the inquest was that Mr Fairey would have been difficult to see. He was wearing dark clothing but also the collision occurred in an area of poor visibility.</li> <li>The speed limit on the road is 20mph. The evidence was that the car was travelling in excess of this.</li> </ol>
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 MATTERS OF CONCERN are as follows. –
	(1) The street lamp nearest to the collision site (8m south of De Frene Rd, on the east side of Mayow Rd) was shrouded by tree foliage causing a large shadow across Mayow Rd. This shadow encompassed the site of the collision and the nearby pedestrian crossing point.  (2) There is a painted "SLOW" on the north bound lane near to the collision site. The

	evidence was that this sign has faded and may not be clearly visible to a motorist.
	(3) There is a speed cushion close to the pedestrian crossing point. The evidence was that a car can straddle this speed cushion without needing to slow down. Also the speed cushion is beginning to break up.
6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you or your organisation has 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 18 February 2019. 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 Persons:
	1. Mr Fairey's mother) c/o Slater & Gordon solicitors
	I have also sent it to:  2. Serious Incident Investigation Unit) 3
*******	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	21.12.18 Philip Barlow