

Timothy W Brennand HM Senior Coroner County of Lincolnshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	 The Secretary of State for Transport, Department for Transport, Great Minster House, 33 Horseferry Road, London SW1P 4DR Head of Highways, Lincolnshire County Council, Newland, Lincoln LN1 1YA
1.	CORONER
	I am Timothy W Brennand, HM Senior Coroner for the County of Lincolnshire, 4 Lindum Road, Lincoln, Lincolnshire, LN2 1NN.
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 18 September 2018 I commenced an investigation into the death of Matthew Bilby, aged 48 years. The investigation concluded at the end of the inquest on 7 March 2019.
	The medical cause of death was determined to be:
	1a. Traumatic Injuries
	There was a short form conclusion of road traffic collision.
4.	CIRCUMSTANCES OF THE DEATH
	On the 6th September 2018, the deceased was riding his the B1166 on the eastern side of the junction with the A16 Hulls Drove, Crowland, Lincolnshire. The deceased drove past on the nearside of standing traffic queuing at the junction and onto the southbound carriageway of the A16 into the path of a DAF Tipper Heavy Goods Vehicle travelling on the A16 where the vehicles were to collide. The deceased was knocked into the air and sustained extensive internal injuries. He remained conscious for a period following the impact, before suffering a cardiac arrest. Despite attempts at resuscitation, he was pronounced dead at the scene.
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.
0.104	The MATTERS OF CONCERN are as follows. –
	The court heard evidence from a number of current regular road users describing the

layout of the A16/B1166 junction as "dangerous", "horrendous", "confusing" and "difficult";

- 2. In evidence the Lincolnshire Police confirmed that this was the fourth fatality at this junction;
- 3. The junction was created as a "staggered" junction in August 2010. Following one of the previous fatalities at the junction further work had been undertaken with red thermoplastic laid in hatched areas:
- 4. Expert evidence received from the East Midlands Operational Support Service Serious Collision Investigation Unit confirmed the junction to be an "accident blackspot" and that the staggered junction created an on-going risk to future road users in that:
 - a. This junction should be reconfigured as a roundabout;
 - b. Alternatively there should be the deployment of considered traffic calming measures (cameras, traffic lights, speed restrictions).

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 28 May 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

- (a) The next of kin
- (b) Lincolnshire Police
- (c) East Midlands Operational Support Service

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.

Date

TIMOTHY W BRENNAND HM SENIOR CORONER

2