REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **Cheshire West and Chester Council - Highways Department**
1	**CORONER** I am Alan Moore Senior Coroner for the coroner area of Cheshire.
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** On 11 October 2017 I commenced an investigation into the death of William John Hignett, aged 66. The investigation has not yet concluded and an inquest has not yet been heard, having been adjourned pending the outcome of criminal proceedings.
4	**CIRCUMSTANCES OF THE DEATH** On 3 October 2017 Mr Hignett was riding a motorcycle on the A556 Chester Road, Sandiway. He came into collision with a HGV. He sustained fatal injuries in the collision. The driver of the HGV was subsequently prosecuted but was acquitted. The trial judge made comments about the location of the collision. These comments have been passed on to me by the Crown Prosecution Service and I consider it appropriate for me to bring them to your attention: The A556 at this location is a dual carriageway with a defined central reservation. The road is unlit and is subject to the national speed limit of 70 mph for a car/motorcycle. The collision occurred during the hours of darkness. The circumstances of the collision were that the HGV had initially been travelling along the westbound carriageway of the A556 (towards Chester). Having passed beneath the overbridge of the A559 Chester Road the driver of the HGV attempted to perform a U-turn in order to head back along the A556, this time in the general direction of Manchester. The A556 at this point has an unusual junction configuration consisting of a filter lane and break in the central median to the offside of the eastbound carriageway, specifically designed for the sole purpose of performing U-turns. The driver of the HGV entered this filter lane and began to perform his U-turn as planned. Having committed to the turn, he moved out of the filter lane and began to enter the eastbound (Manchester bound) carriageway. His vehicle was too long and the turning circle inadequate to enable him to turn his HGV in one fluid manoeuvre. It was therefore necessary for him to 'shunt' his HGV backwards and then forwards again to complete the turn. This U-turn placed him in the Manchester bound carriageway of the A556 for a period of around 11 seconds, with traffic legitimately approaching at 70 mph. For much of that time the nearside of the HGV was presented to oncoming traffic. In that period of time Mr Hignett's motorcycle travelling along the Manchester bound carriageway, and being ridden properly, collided with the near side of the HGV causing

	fatal injuries to Mr Hignett. The nearside of the HGV was illuminated to the by three orange 'marker lights'. Whilst fully compliant with law, in turning where it did, and with the illumination on the side of the HGV, the combination of the turn and the dark national speed limit road are relevant factors.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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 configuration and positioning of the junction; 2. The street lighting at the scene; 3. The surrounding vegetation, which may have affected visibility; 4. The current applicable speed limit.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe 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 **21 June 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 [redacted](wife). 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	**26 April 2019** **SIGNED** [signature] **Senior Coroner, Cheshire**