IN THE WEST YORKSHIRE WESTERN CORONER'S COURT IN THE MATTER OF:

The Inquest Touching the Death of Robert Irwin Norton
A Regulation Report – Action to Prevent Future Deaths

THIS REPORT IS BEING SENT TO:

Director for Regeneration and Strategy

Calderdale Council

Northgate House

Northgate

Halifax

HX1 1UN

1 CORONER

Martin Fleming HM Senior Coroner for West Yorkshire Western

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 20 of the Coroners (Investigations) Regulations 2013

3 INVESTIGATION and INQUEST

On 30/8/17 I opened an inquest into the death of **Robert Irwin Norton** who, at the date of his death was aged 74 years old. The inquest was resumed and concluded on 14th January 20019

I found that the cause of death to be: -

1a Traumatic fractures of thoracic spine

I arrived at a conclusion of Road Traffic Collision

4 | CIRCUMSTANCES OF THE DEATH

At approximately 11.45am on 5th April 2018, Mr Norton was riding his motor cycle on the roundabout of the A644 Wakefield Road having approached the roundabout along Wakefield Road from the Cooper

Bridge direction. Mr Norton was travelling around the roundabout in the offside lane with the intention of joining the M62 eastbound. At t5is time the driver of a Volvo motor vehicle entered the roundabout in the nearside lane, travelling from the Brighouse direction with the intension of travelling straight ahead towards Cooper Bridge. The driver of the motor vehicle was travelling around the roundabout with Mr Norton driving his motorcycle alongside. Once at the entry to the slip road Mr Norton moved from his offside lane into the path of the Volvo resulting in a collision with the off side front wing of the Volvo and causing Mr. Norton to fall from his motor cycle and collide with a wooden fence adjacent to the slip road, tragically causing him to sustain fatal injuries. During the inquest I heard evidence to suggest that the road markings painted on the road surface were worn and difficult to read with the potential for causing motorists to be in the incorrect lane to exit the roundabout onto the entry slip to the M62. Given two lanes on the roundabout and two lanes on the slip road, I heard evidence that this could give the impression that the exiting the roundabout onto the slip road is possible from either lane.

5 CORONER'S CONCERNS

The MATTER OF CONCERN is as follows: -

- To consider the existing legibility of the painted road markings
- To review the existing road lay out in order to prevent potential confusion by motorists

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that has the power to take such action. In the circumstances it is my statutory duty to report to you.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

8	COPIES
	I have sent a copy of this report to:
	 daughter WYP WYP Director for Regeneration and Stratgey— Calderdale Council Chief Coroner
9	DATED this 21/1/19
	Wo thee