	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]**Commissioner for Highways and the Built County Highways Department** **Staffordshire County Council** **1 Staffordshire 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 17th January 2019 I commenced an investigation into the death of Steffan Gareth EVANS, 28 years. The investigation concluded at the end of the inquest on 25th September 2019. The conclusion of the inquest was accident with the Cause of Death being Multiple Injuries.
4	**CIRCUMSTANCES OF THE DEATH** Steffan Evans died at the scene of a road traffic collision on 15th January 2019 near Burton when a car he was driving collided with another car that had just emerged from a driveway and then crashed into a van that was travelling in the opposite direction. A major causative factor was the speed that Steffan was driving at. The road is the B5017 (between Needwood and Burton).
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. – I am aware that following this collision you did make some enquiries concerning this stretch of road (B5017 between Needwood and Burton). However there does appear to be a genuine continuing concern about the volume and speed of traffic on

	this road, bearing in mind the various junctions that there are. I would not ask you to repeat work you have already done, but I wonder if there should be a further review of this stretch of road to see if any steps should be taken to improve its safety.
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 14th December 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 [redacted] (family), [redacted] Virgin Media and Clyde & Co Solicitors for [redacted] 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	**8th October 2019** Andrew A Haigh HM Senior Coroner Staffordshire (South) Coroner's Office No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 Fax No: 01785 276128 www.staffordshire.gov.uk sscor@staffordshire.gov.uk