Regulations 28 and 29 of the coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Monmouth County Council
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 25 September 2018 I commenced an investigation into the death of **Jamie Staley DOB: 24 June 1998.** The investigation concluded at the end of the inquest on **8 October 2019.** The conclusion of the inquest was recorded as **"Accident".** The medical cause of death was **"Multiple injuries"**
4	**CIRCUMSTANCES OF THE DEATH** On 22nd September 2018, Jamie Staley died when he accidentally wandered onto the A40 near Monmouth after a night out drinking with friends. He was struck by a van and died immediately of his injuries.
5	**CORONER'S CONCERNS** During the course of the inquest, 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: - The inquest determined that Jamie died after he accessed the A40 from Monmouth Town, near the Gibraltar tunnels. In considering Jamie's movements on the night he died, the inquest determined that Jamie's mistake had been caused by a combination of not knowing the area and being under the influence of alcohol, however access generally to the A40 in the area of was considered. Police Constable 217, [redacted] gave evidence to the inquest and presented the findings of the Collision Investigation Report. He indicated that there is relatively easy access onto the A40 in

	this area and was surprised that there were no signs which could alert pedestrians to the A40, or to prevent them from entering onto the slip road. Although lack of signage did not contribute to Jamie's death I consider that this is a matter for consideration in preventing pedestrians from straying inadvertently onto this busy road in future. The junction in question is the exit from the A40 travelling northbound immediately having travelled through the Gibraltar tunnels onto the B4233. The co-ordinates are 51.805620, -2.716463.
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. If, however you consider this to be the responsibility of another agency, please let me know as soon as possible.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. I, the Coroner, may extend this 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 necessary
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) • The family of Jamie Staley 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 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	**DATE: 12/11/19** Signed Caroline Saunders, **Senior Coroner for the Area of Gwent**