In the Hampshire Coroner's area

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Hampshire County Council Highways Department** **2. Southampton City Council Highways Department**
1	**CORONER** I am Christopher Campbell Wilkinson, senior coroner, for the coroner area of Central Hampshire, North East Hampshire and Southampton and New Forest
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 13 March 2019 an investigation was commenced into the death of Adam Wilcox, DOB: 08/02/1964. The investigation concluded at the end of the inquest on 20 November 2019. The conclusion of the inquest was that Mr Wilcox died as a result of a traumatic head injury due to a road traffic accident.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 7.40 am on 7 March 2019, the Deceased was walking east from the White Swan pub car park West End on the south side of the A27 Mansbridge Road with a work colleague, on route to a building site at that location. The pair attempted to cross the carriageway to the northern side, to continue their east bound journey when the footpath on the southern side of the road came to an end. The traffic on the road was stationary at the time due to temporary traffic lights and the pair climbed over a low-level ARMCO barrier, dividing the footpath from the carriageway. They entered the east bound carriageway and passed in front of a stationary minibus. As the height of the vehicle prevented any line of sight for them to oncoming eastbound traffic, the evidence established that on emerging from the front of the vehicle into the eastbound carriageway, the deceased looked (left) to the westbound carriage way for opposing oncoming traffic but failed to appreciate the approach of a motorcycle overtaking the stationary traffic in the eastbound carriageway (to his right). Despite a brief effort by his colleague to prevent his forward movement, the Deceased stepped into the path of the oncoming motorcycle whereupon he was struck by the bike and spun into the opposite carriageway. He fell heavily, striking his head on the tarmac. The timescale involved amounted to no more than a second, giving no time for the rider to appreciate the imminent danger and to take avoiding action. The Deceased was conveyed to hospital, but despite significant clinical efforts to save his life, his injuries were determined too catastrophic and he died as a result of the injuries he sustained.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

	The **MATTERS OF CONCERN** are as follows, that: – (1) The A27 Mansbridge Road at the stretch of carriageway from well before the White Swan pub to beyond the scene of this incident (as far as Gaters Hill) does not provide any form of (safe) pedestrian or cycle crossing or any warnings to motorists that pedestrians or cyclist may be crossing along its length. (2) For pedestrians walking (or cyclists not on the carriageway heading) east on the southern side, the only option to travel beyond the scene of this incident is on the northern side of the A27 carriageway. As such, anyone who has not sought to cross the carriageway at a much earlier juncture is either forced to retrace their steps to find another point to cross or (as is more likely) to attempt to cross the carriageway once the path way runs out, where it tapers and stops at the metal barriers and at its junction with the Itchen Navigation. In either event, neither pedestrians nor cyclists have a defined or safe means by which to cross the carriageway and no warnings are given to motorists that they may do so. (3) The A27 Mansbridge Road is a busy, popular and major throughway, running east-west and south of and parallel to the M27. As such it presents an increased risk to pedestrians and cyclists alike. (4) I am advised by the Roads Policing Unit that during their visit to the scene (in the conduct of the forensic examination for this inquest) they themselves saw several pedestrians and cyclists crossing the road, at either end, often climbing the metal barrier where the pavement ended. (5) I am advised that in the past 5 years there have been 15 collisions on the A27 between Itchenside Close and Allington Lane, of which 5 were classed as serious collisions and 10 classed as slight, with 11 occurring within daylight hours. 2 specific incidents (excluding this fatality) involved pedestrians being struck by vehicles.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you/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 Friday 21 February 2020**. 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: 1. [redacted] – brother of the deceased 2. Horwich Farelly Solicitors – For Ageas Insurance I have also sent it to: 3. [redacted], Kingsworthy, Winchester. who may find it useful or of interest. 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	**23 December 2019** **SIGNED BY CORONER:**