REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1.** [redacted] **2. Bill Murphy: Isle of Wight Council Highways Department, St Christopher House, 42 Daish Way, Newport, Isle of Wight, PO30 5XJ**
1	**CORONER** I am Caroline Sarah Sumeray, Senior Coroner for the Coroner Area of the Isle of Wight.
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 21st September 2016 I commenced an investigation into the death of Lee Garfield DANIEL, aged 42. The investigation concluded at the end of the inquest on 22nd December 2017. The conclusion of the inquest was "Road Traffic Collision". The medical cause of death was found to be: 1a Multiple Injuries 1b 1c II
4	**CIRCUMSTANCES OF THE DEATH** 1) Lee Garfield DANIEL was born on 26th September 1973. At the time of his death he was 43 years old and worked as a landscape gardener. 2) At approximately 20.20 hours on Monday 7th September 2016, [redacted] was driving her Nissan Almera in an easterly direction along Coach Lane, Brading, Isle of Wight. She indicated to turn right across Coach Lane at the junction with Park Road. She did not see any vehicle coming in the opposite direction.

	3) Mr DANIEL was travelling on his motorcycle in a westerly direction on Coach Lane, Brading. He pulled out to overtake several legally parked cars (denoted on the attached map), necessitating that he was temporarily travelling on the wrong side of the narrow road. Forensic Collision Investigators have subsequently estimated that he was exceeding the speed limit of 30mph and travelling at approximately 45mph. 4) Mr DANIEL collided with Mrs Warrington's motor car and was thrown off his motorcycle into the road. The driver in the vehicle which was travelling behind Mrs Warrington's car had no opportunity to take evasive action, and Mr DANIEL was struck by this second vehicle too. 5) Mr DANIEL sustained massive traumatic injuries. He was taken to St Mary's Hospital, Isle of Wight, before being transferred by helicopter to Southampton General Hospital. Despite the best efforts of the surgeons, he died there at 4 a.m. on 8th September 2016.
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: – 1. I have concerns about the road markings in Coach Lane, Brading. Had there been double yellow lines at the portion of the road where there were several legally parked vehicles (denoted on the attached map in the 20 metre boxed area), there would have been no necessity for Mr DANIEL to cross over onto the wrong side of the road, thereby affecting his visibility to any vehicle seeking to turn right across Coach Lane into Park Road. The extension of double yellow lines at that 20 metre portion of Coach Lane where cars can currently be lawfully parked can only enhance the safety of that stretch of road for the road users travelling in each direction.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 9th March 2018. 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] 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	 **H.M. Senior Coroner – Isle of Wight** **12th January 2018**