IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Mitica Mihaita Ladunca
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Senior Highway Engineer for Surrey County Council County Hall Penrhyn Road Kingston upon Thames KT1 2DN
2	**CORONER** Ms Anna Crawford, HM Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INVESTIGATION and INQUEST** An inquest into the death of Mitica Mihaita Ladunca was opened on 19 November 2019. It was resumed and concluded on 8 June 2020. The medical cause of death was found to have been: 1a. Adult respiratory distress syndrome AND cerebral infarction 1b. Multiple traumatic injuries 2. Pulmonary tuberculosis The inquest concluded with a short form conclusion of 'Road Traffic Collision'.

5	**CIRCUMSTANCES OF THE DEATH** On 10 October 2019 Mr Ladunca attempted to cross the northbound lane of the A322 in Surrey approximately 425m north of Junction 3. For reasons which remain unknown Mr Ladunca misjudged the situation and unintentionally stepped into the path of a DAF XF 460 articulated large vehicle, resulting in fatal injuries. He died at St. George's Hospital on 8 November 2019. At the collision location there is an asphalt pathway, approximately 1 metre wide, across the central reservation and a gap in the pressed steel barrier. At this point, the kerb drops on both sides of the carriageway for approximately 2.7 metres. This path links to Swift Lane which is staggered across both carriageways. On the southbound side of the carriageway Swift Lane leads to Bagshot Community Recycling Centre and a static home and caravan site for the Traveller Community. On the northbound carriageway side of the carriageway, via a footpath, Swift lane leads to Whitmoor Road and a number of residential properties. During the course of the inquest I received evidence from DC Bloomfield, a Collision Investigator for Surrey Police. He gave evidence that the crossing is uncontrolled and that there is no signage warning drivers that pedestrians may be attempting to cross the road in either direction. Whilst the absence of any signage did not contribute to the particular circumstances of Mr Ladunca's death, I am concerned that it may give rise to a risk of future deaths.
6	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are: - There is an absence of signage warning drivers on the A322 that there is a crossing point for pedestrians which links to Swift Lane across both carriageways. - Consideration should be given to introducing such signage.

7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**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.
9	**COPIES** I have sent a copy of this report to the following: 1. [redacted] 2. Surrey Police Forensic Collision Investigation Unit 3. The Chief Coroner In addition to this report, I am 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, at the time of your response, about the release or the publication of your response by the Chief Coroner.
10	**ANNA CRAWFORD** **DATED this 9th day of June 2020**