# REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

## THIS REPORT IS BEING SENT TO :

The Peak District National Park Authority

## CORONER

I am an Assistant Coroner with Derby and Derbyshire Coroner's Area.

## 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.

## INVESTIGATION

On the 28th January 2013 an investigation was commenced into the death of David Allan Cox. The investigation concluded at the end of the inquest which took place on the 4th October 2013. The conclusion of the inquest was accidental death. The medical cause of death was 1a Death due to immersion.

## CIRCUMSTANCES OF THE DEATH

Shortly after 8.30am on 24th January 2013 David Allan Cox was driving his Toyota Aygo vehicle registration [redacted] from his home along an unclassified single track bridleway at Blackwell Mill, Derbyshire between Blackwell Mill Cottages and Wye Dale Car Park at Topley Head.

Driving conditions were poor, the bridleway being covered in compacted snow and ice. David Allan Cox was driving at a slow speed as he approached the second over bridge as the bridleway bends 90 degrees sharply to the left. At the bend the vehicle ran wide onto the steep riverbank to the offside sliding down and rolling onto its roof into the river below.

David Allan Cox was trapped in his vehicle for some 45 minutes and life was subsequently pronounced extinct at Stepping hill Hospital.

Present in Mr Cox's vehicle was also his daughter who managed to escape.

I heard evidence at inquest that shortly after Mr Cox's vehicle entered the water, [redacted] vehicle which was being used to drive their son to school also left the bridleway at the same location on the bend and her vehicle also slipped down the steep slope of the river bank and overturned into the river below.

My investigation revealed that the track at the point of the bend where the two vehicles left the road is ninety degrees to the left and is extremely narrow and acute with no margin for error.

To the offside is a steep shale covered bank which falls 1.4 metres to the surface of the river at an angle of approximately 40 degrees.

The forensic collision investigator PC [redacted] gave evidence that it would appear that Mr Cox misjudged his speed on the approach to this bend possibly by only a slight amount and this has resulted in the vehicle sliding on the icy surface and onto the river bank where it would have been impossible to regain control. PC [redacted] gave evidence that in driving on the bend as part of his investigation after the collision he himself as an experienced advanced driver was quite frightened driving along the track at the corner and found it a tense experience.

I heard extremely helpful evidence from [redacted] of the Peak District Authority. Who told me that the track is owned by the Peak District Authority and extends ¾ mile between its westerly point at Wye Dale car park and its easterly point at Blackwell Cottages located at the start of the Monsal track.

[redacted] gave evidence to me in respect of the changes that have already been implemented, namely additional signage at the start of the track advising that only residents vehicles are permitted to use the narrow track , 5mph speed limit signs, "Caution blind bend motorists sign your horn" signs and convex mirrors on the bends.

A proposal to place a gate at the start of the track at the car park entrance was refused by Derbyshire County Council.

The statement of [redacted] set out that following the death of Mr Cox, the Authority met with the Residents on 27 February 2013 primarily to discuss the bank repair works and that in addition there was a discussion generally on how the track could be made safer.

[redacted] gave evidence that the Peak District National Authority has commissioned a report from a Hydrological geotechnical consultant from Silkstone Environment to carry out a survey with regards to the feasibility of track widening and bank strengthening along the length of the track but in particular at the bend at the viaduct where Mr and [redacted] vehicles left the track. This survey and report in respect of track widening and bank strengthening would be a precursor to consideration of whether any bollards, barriers or fence could be placed on the track and on the bend and it was envisaged that this would require a further report from a safety expert . [redacted] was unable to comment on any future steps or works but was able to confirm the funding of the survey and report of the Hydrological geotechnical consultant had been granted by the Peak District National Park Authority and that this survey and report would be considered in due course.

[redacted] also identified that in the event that any future works were identified then, as the bank works at the viaduct completed in April 2013 to try and combat erosion had required consents from the Environment Agency, Derbyshire County Council as Highways Authority, Natural England as this was a site of special scientific interest and Network Rail as owners of the viaduct, it was likely that any future works identified would require these agencies input.

## CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern.

In my opinion action should be taken to prevent those circumstances happening again or to reduce the risk of death created by them.

In the circumstances it is my statutory duty to report to you the Peak District National Park Authority.

The matters of concern are as follows and relate to the track at the point of the bend where the vehicles left the track on 24th January 2013 being extremely narrow and acute, leaving no margin for error and creating a risk of other vehicles leaving the track and sliding down the river bank into the river below due to the absence of any barrier.

There is no barrier or wall along the length of the bridleway between the track and the river and I had confirmed in evidence that there are in total three blind bends along the length of the bridleway. The presence of two further blind bends along the same track also causes me concern.

The concern is that circumstances creating a risk of further deaths will occur or will continue to exist in the future relating to the risk of vehicles leaving the narrow bridleway at the blind bends and rolling into the river due to the track being extremely narrow and the absence of any barrier between the bridleway and the river below.

## ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you the Peak District National Park Authority have the power to take such action.

## YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report namely by 10th January 2014. I 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.

## COPIES AND PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted] I have also sent this report to:

1. Derbyshire County Council
2. Environment Agency
3. Natural England
4. Network Rail

As I set out at inquest, they may find it useful and of interest as [redacted] indicated to me in giving evidence that in the event that the Peak District National Park Authority determine works are required to the track then this will potentially require the consent for any works from the Environment Agency, Natural England, Derbyshire County Council and Network Rail as owners of the viaduct.

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 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.

15.11.13 Sophie Cartwright