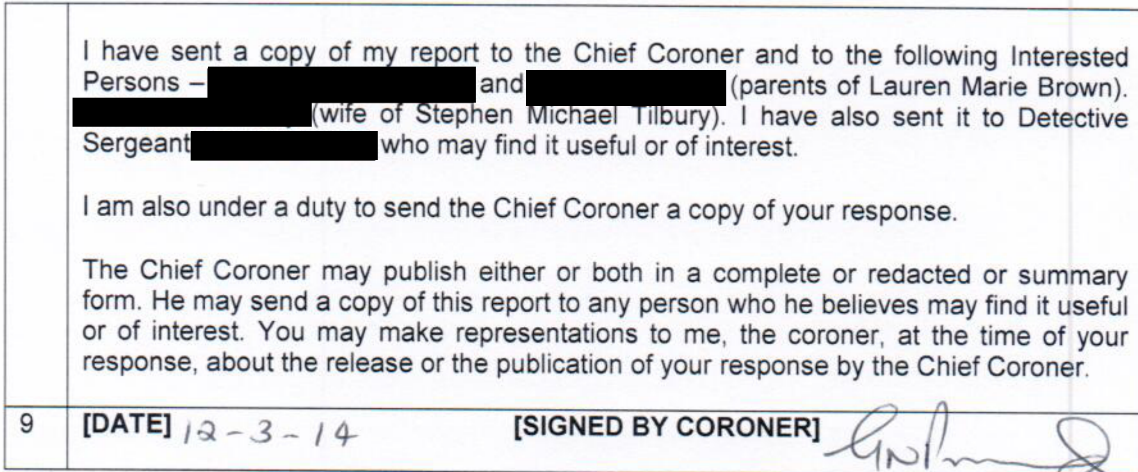
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Cheryl Coppell, Chief Executive, London Borough of Havering, Town Hall, Main Road, Romford, RM1 3BD**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the Coroner Area of Eastern District Greater London.
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 1st July 2013 an investigation was commenced into the death of Stephen Michael Tilbury. On the 5th July 2013 an investigation was commenced into the death of Lauren Marie Brown. These deaths arose from the same facts. The investigations concluded at the end of the inquests which took place on the 7th March 2014. Conclusion of the inquests was as follows: Narrative conclusion relating to Lauren Marie Brown. Miss Lauren Marie Brown was walking along the pavement on the south footway of Crow Lane at approximately 21.50 on 28th June 2013. The driver of a Ford Transit Van failed to negotiate a bend in the road, mounted the pavement and collided with Miss Brown, causing her fatal injuries. The driver had a blood alcohol level well in excess of the legal limit and he approached the bed at excessive speed. Narrative conclusion relating to Stephen Michael Tilbury. On 28th June 2013 at approximately 21.50, Mr Tilbury was driving his Ford Transit Van along Crow Lane, near the junction with Whalebone Lane, South. He failed to successfully negotiate a bend in the road. The van mounted the pavement, collided with a pedestrian, continued through a chain link fence, collided with a tree and then slid down an embankment. Mr Tilbury was not wearing a seatbelt. His blood alcohol levels were well in excess of the legal limit. He approached the bend at excessive speed. He died at the scene from his injuries.
4	**CIRCUMSTANCES OF THE DEATH** Mr Tilbury was driving his Ford Transit Van at approximately 21.50 on 28th June 2013. As he approached a bend in the road at Crow Lane (approximately 80 metres from where Crow Lane meets Whalebone Lane, South) he lost control of his vehicle and hit the trief curb on the offside of the road. (This section of Crow Lane is a single carriageway). The trief curb deflected the vehicle across the road to the south footway where he mounted the pavement and collided with Miss Brown, causing her fatal injuries. His van then continued through the chain link fence, collided with a tree and slid

	down an embankment. Mr Tilbury was not wearing a seatbelt and he died at the scene. Miss Brown suffered a fatal injury to her head. She was taken to the Royal London Hospital but died in the early hours of the 29th June 2013. Mr Tilbury was found to have levels of alcohol of 225mg\100mls (the legal limit for driving is 80mg\100mls). He was also found by the Collision Investigator to have been travelling at a speed in excess of 40mph. The speed limit on that section of the road is 30mph.
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. Evidence was heard from eye witnesses to the collision. One witness who knows the area very well stated, "I am well used to tyres screeching in Crow Lane, people are always driving too quickly in Crow Lane." The Senior Investigating Officer also gave evidence to confirm that local residents are concerned about speeding in that area. 2. The Collision Investigator gave evidence to confirm that in order to reduce the risk of death in the future, steps should be taken to put something physical in place, on the road, to help ensure that vehicles are travelling at the speed limit on approach to the bend. Such physical measures might be speed bumps. Another possibility that he considered was for another trief curb to be put on the south footway (mirroring the opposite curb), to deflect vehicles away from the pavement and back into the road. 3. The Senior Investigating Officer also confirmed that measures should be taken to slow vehicles down. She confirmed that physical measures, such as speed bumps, would be of greater value than illuminated or other signs. 4. The presence of the trief curb had a causative impact upon the death of Lauren Brown. It was the presence of the trief curb which deflected the Ford Transit Van onto the south footway where the collision with Miss Brown occurred. Evidence was heard that the presence of the trief curb is necessary to prevent vehicles that are travelling at speed from ending up on the railway line. This was the reason why the trief curb was put in place. Again, an eyewitness commented that "on the right hand side of the road is a raised concrete kerb. This is there to stop people from crashing through the fence and onto the railway line. I remember the road before this kerb was here and people would come round the bend too quickly and end up on the rails." The Collision Investigator also confirmed that one of his colleagues had dealt with a fatal case where a driver had crashed onto the railway lines. The trief curb therefore appears to be appropriately located. Had Mr Tilbury been travelling at the required speed of 30mph, the trief curb would not have posed a risk to him or Miss Brown.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 the 7th May 2014. 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 – and (parents of Lauren Marie Brown). (wife of Stephen Michael Tilbury). I have also sent it to Detective Sergeant 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	**[DATE]** 12-3-14 **[SIGNED BY CORONER]**