REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

<table>
<tr><td></td><td>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
RE: RUSSELL EDWARD LONG, Deceased
THIS REPORT IS BEING SENT TO:

1. [redacted] Cumbria County Council, Environment, Parkhouse Building, Kingmoor Business Park, Carlisle, CA6 4FA</td></tr>
<tr><td>1</td><td>CORONER

I am David Llewelyn Roberts, senior coroner, for the coroner area of North & West Cumbria</td></tr>
<tr><td>2</td><td>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.</td></tr>
<tr><td>3</td><td>INVESTIGATION and INQUEST

On 10/09/2013 I commenced an investigation into the death of Russell Edward Long, Age 37. The investigation concluded at the end of the inquest on 03/04/2014. The conclusion of the inquest was:
1(a) Pulmonary Oedema
1(b) Aspiration
1(c) Driver of a car overturning in a river

Conclusion: Accident</td></tr>
<tr><td>4</td><td>CIRCUMSTANCES OF THE DEATH

On the 3rd September 2013 the deceased was the driver of a private motor vehicle at night in foggy conditions. The near side wheels went on to the grass verge and the front offside hit a bridge parapet causing the vehicle to overturn and fall into a river.</td></tr>
<tr><td>5</td><td><u>CORONER'S CONCERNS</u>

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. –

The deceased was driving east on the B5307 Road approaching the bridge over the River Wampool between Fingland and Kirkbride. His vehicle left the road. The near side parapet of the bridge had been previously damaged some considerable time ago. Grass had overgrown the area, and end stones and coping stones had been dislodged. What remained amounted to a "ramp". When the deceased's vehicle hit this, the car</td></tr>
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	became airborne and it overturned. It is entirely foreseeable that if the parapet remains in this condition a similar accident could occur in the future. Action should be considered to repair the parapet and erect a barrier to guide vehicles away from the hazard.
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 6th June 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:- [redacted] Messrs. Beaty & Co. [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	**9th April 2014** **SIGNED:**