REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Graham Dolton, Chief Executive, The Highways Agency** **2. Chief Coroner**
1	**CORONER** I am Dr. Peter Harrowing, LLM, Assistant Coroner, for the coroner Area of Avon
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 8th November 2013 I commenced an investigation into the death of Miss Yasmin Mary Richards age 21 years. The investigation concluded at the end of the inquest on 20th March 2014. The conclusion of the inquest was that the medical cause of death was I(a) Chest injuries and the short-form conclusion was that the death was due a 'Road Traffic Collision'.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Miss Richard's death was that on 2nd November 2013 she was driving her Ford Ka [redacted] south along the A46 between Nimlet and Bath. She was alone in the car at the time. As she was negotiating a left hand bend in the section of the A46 known as the 'Hartley Bends' she lost control of her vehicle and crossed over into the the opposing carriageway. At the same time a Range Rover was travelling in the opposite direction and was unable to avoid the oncoming Ford Ka. A collision occurred between the two vehicles and as a result of the collision Miss Richard's received injuries from which died at the scene. She was pronounced dead at 10:00 hours. The driver of the Range Rover was physically uninjured. During the Inquest I heard evidence from witnesses to the collision as well as from PC [redacted] of the Collision Investigation Unit, Avon & Somerset Constabulary who conducted the collision investigation. In evidence I heard that the weather at the time of collision was overcast and dull. The road surface which was in a good state of repair was wet although it was not raining. There was no evidence to indicate that Miss Richard's was travelling in excess of the prescribed maximum speed limit of 60 m.p.h. at the time of, or before, the collision. The Ford Ka was examined by a specialist vehicle examiner of the Collision Investigation Unit who reported that both the front tyres and the rear offside tyre were worn on the inner tread below the legal limit. It was also reported that the tyres were under inflated with pressures of around 50% of the recommended pressure. There were no other defects identified in the vehicle. I found that the condition of the tyres made a significant contribution to to causation of the collision in combination with the speed of the vehicle and the inexperience of the driver.

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) Notwithstanding the contribution made to this collision by the condition of the tyres of Ford Ka this is the second Inquest I have conducted within the past 12 months into the death of a driver who lost control of their vehicle on the same section of the A46. (2)The speed limit in the section of the A46 known as the 'Hartley Bends' should be reviewed and reduced so as to improve the safety of drivers as they approach these bends. (3) The road signs including carriageway markings should be reviewed and improved so as to provide greater warning to drivers as to the severity of the approaching bends. (4) Consideration be given to the provision of 'rumble strips' in advance of the bends so as to further encourage the reduction in the speed of vehicles as they approach the bends.
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 23rd 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] (Parents of the Deceased). 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	**28th April 2014** **Assistant Coroner**