

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Road Safety Casualty Reduction Team, Rochdale MBC

1 CORONER

I am Assistant Coroner for the coroner area of Manchester North

2 CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

3 INVESTIGATION and INQUEST

On the 10th January 2014 I commenced an investigation into the death of Miss Beryl Brinkman. Miss Brinkman died on the 10th January 2014 at the Royal Oldham Hospital. The medical cause of death was 1a) multiple injuries and whilst not causative but contributory 2) ischaemic and valvular heart disease and bronchopneumonia.

4 CIRCUMSTANCES OF DEATH

On the 8th January 2014 shortly before 8 pm, Miss Brinkman was driving her car and emerged from a side road (an un-adopted highway known locally as 'the ramp') onto the main road (an adopted highway known as the A58 Featherstall Road, Littleborough). She was subsequently involved in a serious road traffic collision. The deceased suffered catastrophic injuries, with another driver suffering serious but non-life threatening injuries. Two others people (including a child) were involved in the crash; they were unhurt. It was found, on the balance of probabilities, that the deceased did not 'give way' due to the phenomenon of involuntary acceleration.

Irrespective, during the course of the evidence at inquest and as a result of the serious collision unit investigation it became apparent that the driver's view from 'the ramp' of the oncoming traffic travelling on the A58 (particularly from the right hand side) would have been significantly impaired by the presence of a number of parked vehicles . The vehicles in question were legitimately parked in pre-marked bays.

Greater Manchester Police explained that they were aware of this hazard and that they had been trying to engage the Local Authority, with a view to reviewing the appropriateness/proximity of the parking bays in relation to the junction. However, the Local Authority's view was that as 'the ramp' is an un-adopted highway there was little, if anything, that it could do.

For clarity, the parking bays in question are on the A58 which is an adopted highway. The area itself is busy, residential and the ramp leads to community facilities including a Church and a Hall. There are also small retail businesses in the vicinity.

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. The proximity of the parking bays to the junction, resulting in a marked reduction of driver visibility when emerging on to the A58/parked cars are present. 2. The serious risk of harm/death to road users/pedestrians. 3. The appropriateness of the parking bays. 4. Whether 'the ramp' ought to be designated as an adopted highway. **ACTION SHOULD BE TAKEN** 6 7 YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely the 28th August 2014. I, the Assistant 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 namely: the Deceased's family Greater Manchester Police Traffic Unit Chief Executive (Rochdale MBC) The Deceased's motor insurers 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 from. 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. 2nd July 2014 Date: Signed: 9