REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Constable of Derbyshire: The Secretary of State for Transport:**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester and I conducted these inquests by order of the Chief Coroner for England and Wales.
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 the 23rd November 2009 the inquest into the death of Ryan Reece Bramwell was opened by James Nigel Anderson (Deputy Coroner for Derbyshire). On the 20th November 2009 the inquest into the death of Robert John Graham was opened by Dr Robert Hunter HM Coroner for Derbyshire and on the 19th November 2009 the inquest into the death of Richard Alan Barker was opened James Nigel Anderson (Deputy Coroner).I was ordered by the Chief Coroner of England and Wales to assume jurisdiction of these matters and continue the investigations by order dated the 4th April 2014.The investigations concluded on the 27th August 2014 and the conclusion in each case was one of Accidental Death. The medical causes of death were as follows:- Richard Alan Barker: 1a Cervical vertebral complete dislocation with cord transection. Ryan Reece Bramwell: 1a Multiple trauma 1b Road Traffic Accident Robert John Graham: 1a Multiple soft tissue and bony injuries
4	**CIRCUMSTANCES OF THE DEATH** **On the 13th November 2009 Robert Graham was driving his Ford Mondeo motor car along the A619 from the Chesterfield direction towards Baslow. As he was proceeding up what is known as Chander Hill, his car was struck by an out of control Mercedes coming down the hill in the opposite direction, which had aquaplaned on an excessive amount of water on the carriageway.** **The following day at the same location a line of cars was proceeding from the Chesterfield direction towards Baslow when a Ford Escort RS 2000 overtook them at speed and in so doing it aquaplaned, crossed the centre of the carriageways and collided with an oncoming ambulance before careering down an embankment and into some trees. Two of the occupants of the Ford Escort were killed.**
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. –

	(A) Both the Mercedes vehicle involved in the first collision and the Ford Escort involved in the second collision had tyres which met the requirements for the minimum amount of tread depth, but the rear tyres had considerably less tread depth than those on the front. Evidence was given by the expert vehicle examiners and police accident investigators, that this arrangement with the 'better' tyres to the front, is undesirable and did contribute to the effects of aquaplaning and loss of control in each case. **It occurred to me that at the very least strong advice by tyre fitters should be given to any driver seeking to have the better tyres placed on the front, and preferably it should be made a legal requirement. (FOR THE SECRETARY OF STATE)** (B) During the course of the taking of evidence it became apparent that not all officers within the police service in Derbyshire are aware of their statutory rights to require a road to be closed and to remain closed for up to 7 days for reasons of safety. Indeed, the Traffic Sergeant giving evidence appeared unaware of this power. Had he been aware of this he might have used that power to keep the road closed until it was deemed no longer hazardous. **It would seem sensible that all officers, but especially those specifically directed towards road-policing, should be made aware of this power. (FOR THE CHIEF CONSTABLE)**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have 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 29TH October 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 namely [redacted] (wife of Robert Graham), [redacted] (father of Robert Graham), [redacted] (mother of Ryan Reece Bramwell and Partner of Richard Alan Barker), [redacted] (parents of Richard Barker), [redacted] (wife of Richard Alan Barker) the and to all other Properly Interested Persons. 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	**3rd September 2014** **John Pollard, HM Senior Coroner**