	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Louise Goldsmith, Leader of West Sussex County Council, County Hall. Chichester, West Sussex
1	**CORONER** I am Penelope Anna Schofield, Senior Coroner, for the Coroner area of West Sussex
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 17th December 2014 I concluded the inquest into the deaths of MRS HILIARY MOOCK (aged 83) AND MRS JANICE TAYLOR (aged 74 yrs), who both died on 28th September 2013. I determined that Mrs Moock died as a result of Multiple skeletal injuries including severe head and chest injuries and Mrs Taylor died as a result of Multiple skeletal injuries including severe chest injuries and a ruptured heart and that their deaths were the result of a Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** 1. On Saturday 28th September 2013, at approximately 10.45pm [redacted] was driving his Volkswagen Golf motor car northbound along the A285 from Chichester to the home address of his friends, [redacted] and Mrs Taylor namely [redacted] They had all been to the Theatre in Chichester. 2. [redacted] and Mrs Moock were guests of [redacted] and Mrs Taylor and had been planning to stay with them over the weekend of 28th and 29th September 2013 3. [redacted] was at the time accompanied by Mrs Janice Taylor, who was sat in the front passenger seat, [redacted], who was sat in the rear offside seat, and Mrs Hilary Moock who was sat in the rear nearside seat. [redacted] and other guests had gone is a separate car. 4. Travelling south on the same road and at the same time was [redacted] who was driving his Honda Civic motor car. The evidence he gave at the Inquest was that he was driving at between 55 – 60 miles. The speed limit for this road was the national speed limit of 60 miles per hour. [redacted] admitted that he had consumed at least 1.5 pints of lager. A road side breath test showed that his alcohol reading in breath was 21 micrograms which was within the legal limit of 35 micrograms of breath. 5. As [redacted] approached the entrance to St Mary's Farm and Benges cottages it appears that there may have been some confusion by the occupants in the car as to exactly where the entrance was. [redacted] was relying on Mrs Taylor giving him instructions. The entrance is difficult to negotiate as it is close to the brow of a hill, there is no lighting and the entrance is straight onto unmade road which is full of pot holes. 6. It appears that as [redacted] approached the entrance he slowed right down and then turned right and travelled across the southbound lane. As he did so he was impacted broadside (in a T-bone configuration) by [redacted] car which was travelling through the junction. 7. Tragically both Mrs Moock and Mrs Taylor sustained fatal injuries from the collision.

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 A285 is an ancient rural road and it does not meet the design standards of a modern road. It is noted that this road features in the list of persistently higher risk roads under the EuroRap fatal and serious collisions per kilometre travelled analysis. (2) The location of this accident is in a dark unlit area and there is no clear indication that there is an entrance into St Mary's Farm and Benges Cottages. This is a difficult turn to make from the Northerly approach as the line of sight to the brow of the hill is only 90 metres. (3) There is only limited amount of asphalt at the entrance into St Mary's Farm and Benges Cottages of some 2 metres. The road then becomes "unmade" and uneven with several large potholes. It appeared from the evidence that because of this drivers are somewhat cautious when driving into the road. (4) This hesitation could cause drivers to slow down their approach into the road and therefore put them at risk from vehicles travelling in the opposite direction. I consider that there is a risk that future deaths may occur in similar circumstances and action should be taken to reduce the risk
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 19th March 2015. 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: 1. [redacted] 2. 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: 23rd January 2015 SIGNED: Penelope Schofield, Senior Coroner West Sussex**