	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Head of Technical Services Management Team, Durham County Council, County Hall, Durham, DH1 5UQ**
1	**CORONER** I am Crispin A Oliver, Assistant Coroner, for the coroner area of County Durham and Darlington.
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 7th March 2016 I commenced an investigation into the death of Nathan Luke Charman, born 3rd June 1994. The investigation concluded at the end of the inquest on 20.07.2016. The conclusion of the inquest was that Nathan died from a severe head injury on 5th March 2016 at approximately 01.25 hours at Long Lane, Todd Hills, Binchester, County Durham when his car left the road, hit a tree with such force as to disable the airbags and rolled. The road was icy and had not been gritted. It had been a Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** Nathan was travelling on a road with which he was familiar. He was travelling home after work. He had a clean license. The incident was unwitnessed but from the evidence certain facts were clear. He was not under the influence of drink or drugs. The car was in good working order and he was wearing a seatbelt. There was nothing to suggest that he was driving at a speed above the legal speed limit. His mobile phone was in a back pocket and therefore he was not using it. The evidence of the Police Officer from the Collision Investigation Unit of Cleveland and Durham Police Specialist Operations Unit and of the Senior Officer overseeing the investigation was that the probable cause of Nathan`s car leaving the road was the road surface being slippery and icy. They described its condition as "unsafe". The officer of the Collision Investigation Unit said it had been too dangerous to conduct a post incident skid test. Other Officers attending the scene were reported to have stated how they had nearly lost control of their 4 x 4 Police vehicle at the same point in the road. The Officers giving evidence concurred that a "microclimate" at the point where Nathan had left the road had produced extremely icy and slippery conditions which were "freakish and extreme" which had resulted in the incident in which Nathan had been killed. The road was untreated. The evidence of the Highway Services Manager who had taken the decision at 12.00 on Friday 4th March, based on the 11.42 hours weather forecast, with regard to winter maintenance action for Friday evening and Saturday morning was that he was following the policy (which he exhibited to his statement) and the weather forecast. He reviewed the decision at 18.00 on Friday 4th March, relying on a 17.40 hours forecast, but did not change it.
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 decision by the Highway Services Manager followed the policy and applied the weather forecast. The unsafe road conditions where the incident occurred were restricted to that immediate locality. However, neither the policy nor the decision making process accommodated the possibility of extreme variations in road conditions or the existence of what the Police identified as "microclimatic" conditions at particular points and " extreme and freakish" conditions that led directly to this death. 2. The winter maintenance policy does not provide for variations in conditions during the time between decisions being made concerning winter maintenance action. 3. The evidence of the Highway Services Manager was that this incident has not prompted a formal review of the decision making process or the policy in the light of this incident, or any form of formal learning or information sharing in and by Technical Services Management Team.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 Friday 16th September 2016. 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] 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]** 21 Jul 2016 **[SIGNED BY CORONER]**