REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used after an inquest.

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Merseyside Passenger Transport Authority Merseytravel, PO Box 1976, Liverpool, L69 3HN

1 CORONER

I am André Joseph Anthony Rebello, Senior Coroner, for the area of Liverpool & Wirral

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 23rd January 2017 I commenced an investigation into the death of **Paul Michael BRIGGS**, Aged **43**. The investigation concluded at the end of the inquest on 28th February 2017.

The medical cause of death was:

la Minimal Conscious State lb Traumatic Head Injury

The conclusion of the inquest was: Road traffic collision

4 CIRCUMSTANCES OF THE DEATH

On the evening of 03/07/2015 Paul Briggs was riding his own motor cycle on his way to work at Merseyside's Roads Policing Headquarters in Liverpool. As he rode up the Borough Road access road to the Birkenhead Tunnels, an oncoming vehicle, a Nisan Micra, veered onto his side of the road, across solid white lines and a collision occurred. Paul suffered multiple fractures and also a very traumatic brain injury which left him in a minimally conscious state. He was treated in the Walton centre until a Court of Protection order was made in December 2016 approving a palliative care plan. On the 11/01/17 artificial nutrition and hydration was withdrawn. Paul was pronounced having died at 09.15Hrs Saturday 21st January 2017.

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. -

Though there is appropriate signage, a two way sign as the carriageways merge and though there are double white lines dividing the tunnel bound carriageway from the Liverpool bound carriageway; this incident occurred resulting in a tragic death. It is unclear as to why the Nissan Micra strayed onto the wrong side of the road but had the double white lines also included rumble strips – (as in the tunnel itself and similar to the lines next to motorway hard shoulders)- this would minimise the risk of inadvertently straying into the oncoming lane especially at quiet times when the side barriers and the bend inhibit visibility of oncoming traffic.

It is now some 20 months after this tragic incident which proved fatal and risk assessments as to the risk of this eventuality, with appropriate remedial action should be nearing completion.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 28th April 2017. 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 the family of Mr Briggs, the driver of the Nissan Micra, Merseyside Police.

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

André Rebello

Senior Coroner for the City of Liverpool & Wirral

Dated: 28th February 2017