ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Essex Highways, County Hall, Chelmsford, Essex. CM1 1QH.**
1	**CORONER** I am Mrs Eleanor McGann, HM Area Coroner, for the area of Essex.
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** I commenced an investigation into the death of Mr Roy Lynch on the 15th March 2017 who was aged 86 years having been born on the 11th April 1930. The investigation concluded at an inquest on the 4th July 2017. The conclusion of the Coroner was that the death of Mr Lynch was an accident.
4	**CIRCUMSTANCES OF THE DEATH** On the 10th March 2017 the car driven by Mr Lynch went into the back of a stationary vehicle on the B184, Dunmow Road between Great Easton and Great Dunmow [redacted] The stationary vehicle was on a section of road subject to the national speed limit where the available view was just over 100 metres, due to a slight left hand curve. There are no restrictions to prevent parking or stopping at that location. .
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. Cont.....

	The **MATTERS OF CONCERN** are as follows. – 1). A vehicle travelling at 60mph would take 4 seconds to travel the distance of 100 Metres. In that time the driver must realise there is a stationary car, react to it And apply emergency braking in order to avoid a collision. 2). There are no restrictions on stopping a vehicle at that location although there is a Large safe parking area approximately 65 metres away. 3). If the stationary vehicle had been parked in the parking area Mr Lynch might still be Alive today.
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 29th August 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 – Mr Lynch's family, Forensic Collision Investigation Unit (FCIU) and Serious Collision Investigation Unit (SCIU). 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** 5.7.17. **CORONER** E. McGANN.