HM SENIOR CORONER
Lincolnshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Highways Department Lincolnshire County Council
1.	**CORONER** I am Paul Duncan Smith, Area Coroner for the Coroner Area of Lincolnshire, 4 Lindum Road Lincoln LN2 1NN
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3.	**INVESTIGATION and INQUEST** On 28 October 2016 I commenced an investigation into the death of Harry James Jellicoe aged 26. The investigation concluded at the end of the inquest on 27 March 2018. The conclusion of the inquest was that Mr Jellicoe died as a result of a Road Traffic Collision, the medical cause of death being: 1a. Traumatic Brain Injury 2. Rib Fractures and Lung Contusions
4.	**CIRCUMSTANCES OF THE DEATH** 1. On 16 October 2016 Mr Jellicoe was driving his MG TF motor car, registered number YT 03 OSU eastbound on the A151 road between Colsterworth and Corby Glen, Lincolnshire. Although not raining at the time, it had previously rained heavily and the road surface was wet. 2. Shortly before reaching Corby Glen Mr Jellicoe reached a point at which the road passed underneath a bridge carrying a railway line. 3. Mr Jellicoe drove underneath the bridge. The road turned to his right at an angle of over 30 degrees and began to climb uphill. As Mr Jellicoe followed the road, he lost control of his vehicle which left the carriageway to the nearside, suffering a heavy impact with a roadside tree. Mr Jellicoe suffered severe injuries from which he died in hospital some days later. 4. Mr Jellicoe had purchased his vehicle from a reputable garage earlier in the year. It had been subject to an MOT test on 17th June 2016 and had been given a certificate. No advisory matters were raised at that time. 5. Despite that history, the vehicle was found to have front tyres which were each extensively worn and displaying significantly less than the legal minimum depth of tread required. Evidence was received that the pattern of wear was likely to have resulted from a longstanding misalignment of a steering or suspension component within the vehicle. 6. The cause of the loss of control and consequent road traffic collision was found to be a combination of the speed at which the vehicle was driven, the wet road conditions prevailing at the time and the lack of tread on the front tyres which arose from the manner in which the vehicle had been set up.

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. – (I) The section of road where this incident occurred is subject to no specific speed restriction. The national speed limit applied. (II) The nature of the bridge construction imposes a height restriction on vehicles passing underneath of 4.6m (15 Feet 3 Inches). (III) The arch of the bridge is such that the full height is only available to vehicles using the centre of the carriageway. The bridge properly bears clear signage advising of that risk and guiding high sided vehicles towards the centre of the carriageway. (IV) I received evidence that on both approaches to the bridge there is clear signage warning drivers of the existence of the bridge and its height restriction, and advising high sided vehicles to utilise the centre of the available carriageway. (V) Although traffic approaching from the West has a clear view of the bridge for some considerable distance, the nature of the landscape is such that it is not possible to see any significant distance beyond the bridge arch to identify traffic, especially high sided vehicles which may be occupying the centre of the carriageway, approaching from the East. (VI) Similarly, and for the same reasons, traffic approaching from the East has a much reduced view of the approach to the bridge and cannot identify traffic approaching from the West. (VII) In light of the current signage and proper recommendation that high sided vehicles utilise the centre of the carriageway, given the restricted line of vision through the bridge arch, you may feel that the current speed limit is too high and requires revision. Likewise, there is no signage indicating priority of passage where high sided vehicles are required to utilise the full carriageway. (VIII) Whilst I received evidence that there have been very few reported collisions involving HGV's at this location, there was a clear consensus among the local drivers who gave evidence that this location posed a significant potential hazard, for the reasons given above, particularly for those motorists who were not familiar with the area.
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 13 June 2018. 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 A) [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.
	18th April 2018 ..... **P D Smith** **Area Coroner**