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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Anthony May – Chief Executive of Nottinghamshire County Council**<br>**2. [redacted] – Group Manager of Highways**<br>**3. Chief Coroner**<br>**4. Family** |
| 1 | **CORONER**<br><br>I am Mrs Heidi Connor, assistant coroner for the coroner area of Nottinghamshire. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 20 September 2017 I commenced an investigation into the death of Molly Jean Mills. The investigation concluded at the end of the inquest on 15 February 2018. The conclusion of the inquest was Road Traffic Collision. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The family advised us that Mrs Mills preferred to be referred to as Jean, so I will respect that wish in this report.<br><br><u>Brief Summary</u><br><br>Jean was driving on the A6006 Melton Road, near to the village of Stanford on Soar in Nottinghamshire, on the morning of 6th June 2017. She was involved in a collision with a lorry at the junction which has entrances to Home Farm on one side, and the Defence and National Rehabilitation Centre ('DNRC', currently under construction) on the other.<br><br>Jean was travelling in the direction of Zouch, and made a right turn towards Home Farm, into the path of a lorry travelling on the A6006 towards Rempstone.<br><br>Jean's injuries were initially not thought to be life-threatening, but she died in hospital on 17 July 2017 after contracting bronchopneumonia, because of the rib fractures she suffered in the collision. Although Jean also suffered a fall in hospital, I concluded that the injuries she sustained in the collision were the cause of her bronchopneumonia and death. I was assisted in this respect by evidence from a consultant radiologist and a Home Office pathologist.<br><br><u>The Collision</u><br><br>We had clear evidence (via tacograph and dashcam footage) that the lorry was not speeding. The driver was not under the influence of alcohol. Whilst the driver reacted quickly and applied his brakes when Jean's vehicle appeared in front of him, he did not have sufficient opportunity to avoid the collision. I found no fault with the lorry driver's manner of driving or the action he took to try to avoid the collision.<br><br>I found that Jean made her manoeuvre without checking adequately for oncoming traffic. Driver error undoubtedly played a part. |

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| | However, I also reached the conclusion that the layout of the junction made a collision like this more likely. The layout poses a risk of future deaths. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>**The key areas of concern are :**<br><br>1. There is a significant incline on this road (in the direction the lorry was travelling). This makes the visibility issues referred to below much more significant.<br>2. If there are vehicles in the central carriageway waiting to turn right into both the DNRC and Home Farm, as here, there is a risk of them having an inadequate view of oncoming traffic on the A6006, before making their turning manouevres.<br>3. This is the case in both directions, but particularly for vehicles travelling in the direction towards Rempstone, because of the incline of the road.<br>4. The evidence of the lorry driver was that he did not see Jean's car until she turned in front of his vehicle.<br>5. The evidence of the Forensic Collision Investigation Unit officer was that Jean's view would have been largely or completely blocked by vehicles waiting to turn right into DNRC until 2.93 seconds before impact.<br>6. Witness evidence suggested that the right turn into DNRC is often backed up, resulting in queues in this central lane, making visibility worse. It was suggested this may be partly because of a security barrier in the DNRC grounds, which causes traffic to back up. This is likely to remain a busy junction when the DNRC opens.<br>7. If the oncoming vehicle (coming up the incline towards Rempstone) was a standard vehicle, rather than a lorry, visibility would be even worse, given that the cab of a lorry is higher up.<br>8. Similarly, if the vehicles waiting to turn right (into Home Farm and DNRC) were lorries or other large vehicles, such as ambulances, then visibility concerns would be heightened further.<br>9. There is an element of uncertainty at the junction – where both vehicles are turning right – there is no clear indication of who has right of way or how the vehicles should make their manoeuvres.<br>10. There is a solid double white line on the road just before the turning into Home Farm. This requires a driver turning right to make a sharp-angled turn.<br>11. The signs on either side of the junction warn oncoming traffic of the DNRC junction, but not the Home Farm junction. The fact that the Home Farm road is a private road should not reduce the need for adequate safety warnings to drivers.<br>12. I have been provided with a Nottinghamshire County Council Road Safety Audit regarding this junction, which is dated 21.9.15. This contains the following extract :<br>*During the site visit we were approached by a member of the public (apparently the owner) from Home Farm, opposite the Stanford Hall Access. He brought to our attention an issue which he felt had safety implications. Drivers intending to turn right into the Home Farm access have to wait on their side of the A6006 centre line to give way to oncoming traffic, as previously. They then have to turn across both the right turn lane and the Eastbound A6006 traffic lane. If a number of vehicles were occupying the right turn lane, he felt there would be potential to mask oncoming A6006 vehicles from view. Although the existing situation requires a right turner to to wait in the westbound lane of the A6006, he also felt that he would be at greater risk of shunt type accidents than previously.* |

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| | 13. Sadly, this appears to have been the very risk that played a part in this collision. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you / your organisation have the power to take such action.<br><br>The fact that a Regulation 28 report has been issued should not be interpreted as a criticism of the recipient organisation. This point has been made clearly in the case of *R (Dr Siddiqui and Dr Paeprer-Rochricht) v Assistant Coroner for East London*. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 18 April 2018. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to Jean's family.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **21.2.18** ***H.J.Connor*** |