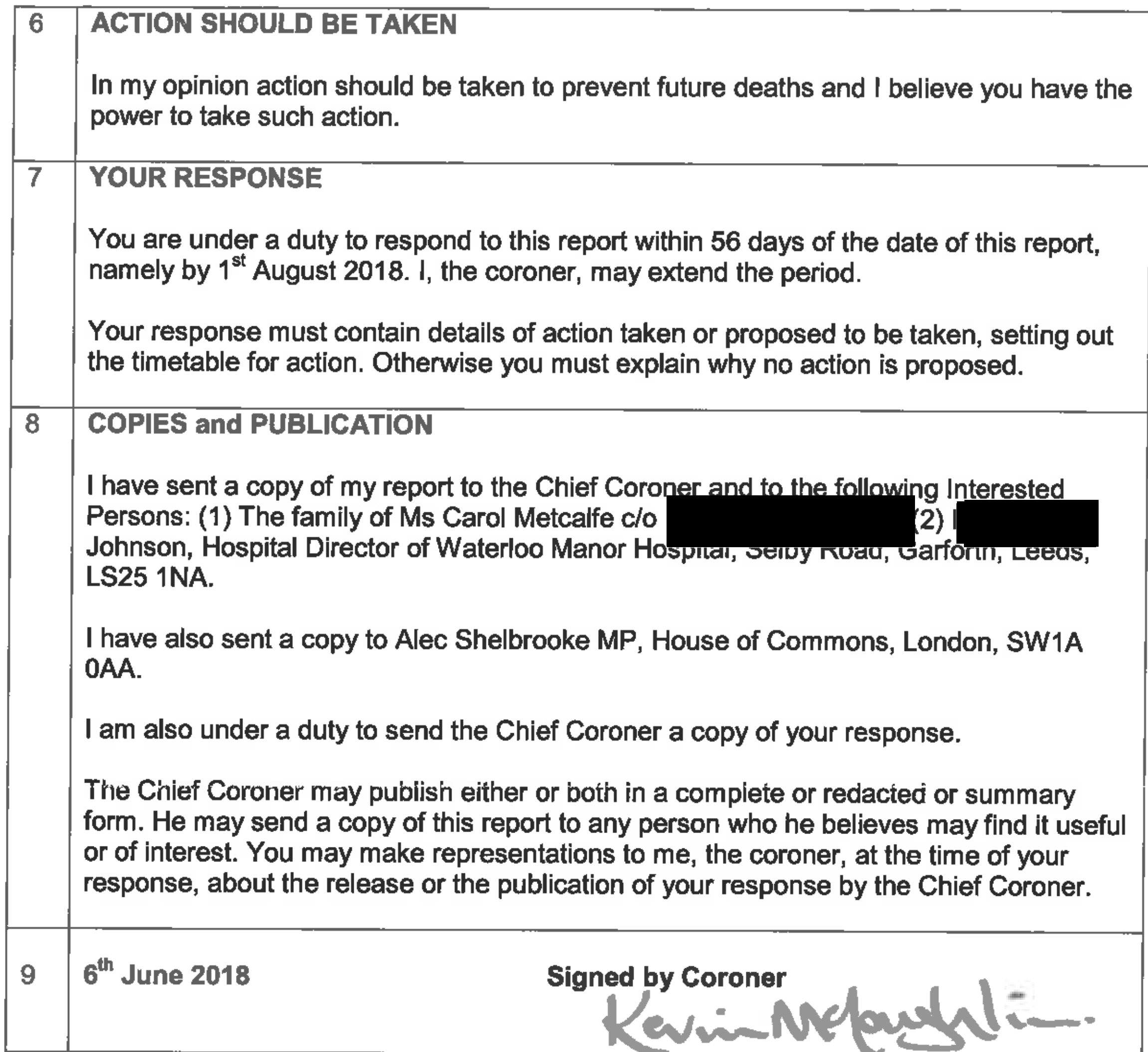
ANNEX A

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:** **Leeds City Council Highways Department, Selectapoint 6, Ring Road, Middleton, Leeds, LS10 4AX -**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner for the coroner area of West Yorkshire (Eastern)
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 1st November 2016 an investigation was commenced into the death of Carol Metcalfe, aged 41. The investigation concluded at the end of the inquest on 6th June 2018. The conclusion of the inquest was a Narrative indicating that she died from chest and abdominal injuries after being struck by a heavy goods vehicle.
4	**CIRCUMSTANCES OF THE DEATH** The location of the fatal road traffic collision involved in the Inquest was on the A63 Selby Road opposite a low secure psychiatric unit called Waterloo Manor Hospital. The patients treated there have typically been compulsorily detained ("sectioned") under the Mental Health Act 1983 due to their complex mental illnesses. Many are prescribed medication which may leave them drowsy. An integral feature of the rehabilitation of such patients is to undertake escorted (or unescorted) leave from the hospital. It is, therefore, likely that patients subject to medication will be crossing the busy A63 Selby Road dual carriageway, which is subject to a 50 miles per hour speed limit. The situation described gives rise to a concern that deaths may occur as people such as patients seek to cross the dual carriageway to get to the bus stop.
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. – The need for measures to be taken to protect pedestrians crossing the A63 dual carriageway in the vicinity of Waterloo Manor Hospital.



6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 1st August 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: (1) The family of Ms Carol Metcalfe c/o [redacted] (2) [redacted] Johnson, Hospital Director of Waterloo Manor Hospital, Selby Road, Garforth, Leeds, LS25 1NA. I have also sent a copy to Alec Shelbrooke MP, House of Commons, London, SW1A 0AA. 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	**6th June 2018** **Signed by Coroner**