REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS	
	THIS REPORT IS BEING SENT TO: **<u>The Chief Executive – Ms Josie Wragg:</u>** Slough Borough Council, St Martins Place, 51 Bath Road, Slough, Berkshire, SL1 3UF.
1.	**CORONER** I am Mrs Heidi J. Connor, Senior Coroner for the coroner area of Berkshire.
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 conducted an Inquest into the death of June Russell that was heard at Reading Town Hall on 2nd April 2019. I recorded a conclusion of road traffic conclusion.
4.	**CIRCUMSTANCES OF THE DEATH** The family asked us to refer to the deceased as "June" at the inquest. I have reflected that request in this report. June was involved in a road traffic collision on the 2nd May 2018. She was the passenger in a Kia Venga driven by her husband. His vehicle was in collision with a Ford Galaxy people carrier driven by a taxi driver. The Kia was being driven south on the B470 High Street, Langley, approaching a traffic light controlled junction with the A4 London Road. The Kia was in a left turn only lane at the junction, but drove straight ahead into the junction, colliding with the Ford Galaxy, which was continuing on the A4 across the junction towards Slough town centre.

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The evidence was clear that there was little that the taxi driver could have done to avoid this collision. Evidence from dashcam footage and from all of the key witnesses involved was consistent.

The Crown Prosecution Service did not prosecute in this case, given the tragic outcome. It is appropriate to be clear from the outset that driver error has undoubtedly played a part in this collision. I have considered whether there were mitigating factors which make further incidents at this junction likely, with the risk of future deaths occurring.

I concluded at the inquest that speed, weather conditions and the condition of the two vehicles involved played no part in this incident.

During the inquest, I took evidence from a Traffic Management Officer with Thames Valley Police, [redacted] He has carried out some research into historical collisions which have occurred at this junction. This road layout was changed in July 2014. In the 5 years before this, there were 4 recorded collisions at this junction. Two of these involved similar circumstances to this collision. Since July 2014 (a less than 5 year period), there have been 13 reported incidents. Six of these involved similar circumstances. The number of incidents is undoubtedly much higher since July 2014.

The evidence suggests that a high proportion of the collisions which have occurred at this junction fall into one of two categories namely where the left hand lane is treated as a straight on lane (in this case), or where vehicles have contravened red traffic lights whilst travelling on the B470 from lane 2, confusing the left turn filter arrow. Whilst driver error may well have played a part in many of the incidents, they can be categorised as driver error with common themes.

I was made aware of ongoing work that Slough Borough Council has undertaken in early 2018 to improve safety at this junction. These followed concerns raised by police and neighbourhood groups in November 2017. This has included:

(1) Changes to the positioning of the secondary traffic lights. These were moved away from the southbound secondary head so that drivers cannot become confused. This was completed on 2nd May 2018 (the day of the collision).

(2) Drawing a left turn guidance line for southbound lane 1, left turn – completed 5th February 2018.

(3) Drawing a yellow box junction – although this was primarily to prevent the exit becoming blocked. This was completed on the 5th February 2018.

A number of other matters are, I was told, being considered but have not yet been

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	completed. These include: (1) Moving the southbound secondary head on pole 9 – to bring drivers' attention to the stop line. (2) Creating bigger lane designation signs before the junction. (3) Creating a regulatory blue left arrow to the southbound left turn-head to reinforce what is allowed from that lane. I heard in evidence that the words "left turn" painted on the road had become very faded by the time of this incident. It was however accepted that, for the majority of the time, this sign would be covered by traffic using the lane. I also heard that there are a number of signs on the same pole as the left hand turn sign before the junction, creating distraction for drivers. In addition, Mr Edmond was of the view that, given the layout of this junction, the line of sight for drivers using the left hand only lane may give false reassurance to drivers considering going straight on, as the driver did in this case.
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 could occur unless this action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: – I consider that Slough Borough Council should take action to address the injury collision rate at this junction. Some work is ongoing, but this has been the case for over a year. This consideration should include: (a) Improvements to the signs at and before this junction. (b) Primary and secondary traffic light heads. (c) Layout and line of sight on the approach to this junction from the B470 High Street Langley. (d) It was not clear during the evidence whether the traffic lights in question are LED lights, which may assist in this respect as well.
6.	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe your organisation has the power to take such action.

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7.	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **12th June 2019.** 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 actions is proposed. Given that these matters have been under consideration for some time, a lengthy extension will presumably not be required.
8.	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to June's family. I have also sent a copy to the Road Traffic Team at Thames Valley 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.	**17th April 2019**  **Mrs Heidi J. Connor** **Senior Coroner for Berkshire**