REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: , Head of Highways, Isle of Wight Council, County Hall, High Street, Newport, Isle of Wight, PO30 1UD. , Service Director, Ringway Island Roads Limited, St Christopher House, 42 Daish Way, Newport, Isle of Wight, PO30 5XJ. CORONER 1 I am Caroline Sarah Sumeray, Senior Coroner for the Coroner Area of the Isle of Wight. 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. **INVESTIGATION and INQUEST** 3 On 15th April 2019 I commenced an investigation into the death of Yvonne COPLAND, aged 64. The investigation concluded at the end of the criminal proceedings on 13th July 2020. As a consequence of convictions being recorded in respect of causing death by dangerous driving (and other associated matters relating to this collision), and the facts having been fully ventilated in the Isle of Wight Crown Court before sentence on 13th July 2020, I have considered that it is not appropriate for me to resume the inquest proceedings in this case. The medical cause of death was found to be: 1a Neck and Trunk Injuries 1b 1c Ш CIRCUMSTANCES OF THE DEATH 4 1) Yvonne COPLAND was born on 10th December 1954 in Newport, Isle of Wight. At the time of her death, she was 64 years old. She resided in Newport, Isle of Wight and was a Cancer Care Co-ordinator.

- 2) On Sunday 14th of April 2019 Mrs Yvonne COPLAND and her husband

 were conveying their son

 to Yarmouth in

 was the driver of this vehicle with

 as the front seat passenger. Yvonne COPLAND and

 were rear seat passengers. The vehicle left the family
 home address in Newport, Isle of Wight just before 13:00 hours. The vehicle
 was travelling in a westerly direction along the A3054 towards Shalfleet and
 Yarmouth.
- 3) Whilst travelling along the A3054 and at the junction of FOREST ROAD and WHITEHOUSE ROAD a collision took place with a double-decker bus index and a silver Mini Cooper being driven by index being driven by . The silver Mini Cooper was travelling south along WHITEHOUSE ROAD towards the A3057 from the direction of Great Thorness. was unfamiliar with the road layout and failed to see or act upon the road signage indicating that there was a junction ahead at which she needed to give way. In so doing she has collided with the double-decker bus driving east along the A3054 from Shalfleet towards Newport. In an attempt to avoid a collision with vehicle as it emerged into the junction without stopping from the A3057 into the A3054 immediately in front of the bus, the bus driver instinctively swerved to the right and in doing so he was completely unable to avoid colliding with the vehicle containing Mrs COPLAND and her family.
- 4) Police and ambulance crews were quickly on scene and further support was requested including 4 air ambulances. Upon their arrival, ambulance staff noted that Yvonne COPLAND had been removed from her husband's car and was being given CPR by members of the public. Paramedics and other medical support took over providing emergency medical treatment for Yvonne COPLAND but sadly she was pronounced dead at the scene at 13.16 hours.
- had to be extricated from his vehicle and was taken immediately by helicopter to Southampton General Hospital with very critical life-threatening injuries. He was taken to surgery and his condition was considered to be life-threatening for a considerable period. He was unconscious for a month after the collision and subsequent surgery and required several other surgeries whilst an inpatient. His injuries have been life-changing, and he was unable to go home to convalesce but had to relocate to a Care Home, and now lives with one of his daughters because due to his injuries, he is unable to live alone.

- was conveyed to Southampton General Hospital with several major injuries which required significant surgeries.

 was flown to Brighton Hospital with life-threatening injuries and was placed into an induced coma for a week. Three months after the incident, he was still in a wheelchair and long-term has suffered and continues to suffer with PTSD. All three men suffered life-changing physical and psychological trauma as a consequence of this collision.
- psychological injuries. It is fair to say that whilst the collision with the Fiat Bravo driven by was unavoidable, in taking the action that he did, saved the lives of many of his passengers on the bus and prevented them from receiving serious injuries as his actions prevented the bus falling into the ditches which are present on both sides of the road.

5 CORONER'S CONCERNS

During the course of sentencing hearing before Her Hon Judge QC, the learned Judge's sentencing remarks 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: -

- 1. In her sentencing remarks, Her Hon Judge QC said: "...It is right and fair that I should make the observation that this is not, perhaps, the easiest of junctions. It is not the first time that a serious road traffic collision has taken place at this particular junction.
- 2. "Whitehouse Lane has high hedges and it does not afford a good view of the major road, although an approaching double-decker bus would probably have been visible to you. In addition to that the road may be somewhat deceptive when travelling along Whitehouse Lane in that a person who fails to observe the signage and the road markings could read the road as continuing straight across, which is the way in which you recall reading the road, and I accept that, coupled with your over reliance on the audio of your satellite navigation system, that is how you saw it, having failed to observe the clear warnings on the approach to the junction. Two "Give Way" signs, road markings and a change of surface.
- 3. "It is incumbent upon a driver to observe the road and most importantly the road signage, the road markings and the change of road surface, which were clear.

In addition to that, three or four seconds before you reached the junction, another vehicle emerged from the road opposite Whitehouse Lane and should have been a visible warning to you. You were, however, a very inexperienced driver which may have contributed to your error. By the time you realised what was happening, it looks like you must have braked hard at that point, it was too late."

- 4. In the aftermath of the crash, a petition was launched which gained nearly 7,000 signatures calling for the Isle of Wight Council to install traffic lights at the crossroads, in a bid to improve road safety and prevent further collisions.
- 5. Accident data from the Isle of Wight Council and Island Roads show there is a 'high probability' of a crash occurring at that junction at least once every year, and it is 'likely' that between 25% and 50% of those accidents could kill or seriously injure someone.
- 6. In the last 5 years, I am informed that there have been 7 recorded collisions which have occurred at this junction the one involving Mrs COPLAND was clearly one where a fatality occurred, and number of others were seriously injured in this incident. I also understand that there have been 3 other serious collisions at this location with 6 of those collisions involving vehicles exiting Whitehouse Road on to Forest Road.
- 7. Forest Road is the main strategic route from Newport to the West Wight and is thought to be used by approximately 10,000 vehicles a day and its junction with Whitehouse Road is currently in the top 10 potential safety schemes on the Island's Highways Safety and Improvement Register.
- 8. Whilst I am aware that some measures have been taken by the Isle of Wight Council to reduce the likelihood of a collision in the future by realigning a hedge, I am concerned that this measure does not go far enough to make this junction significantly safer for all road users in the future.

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 3rd May 2021. 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:

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



H.M. SENIOR CORONER - ISLE OF WIGHT

8th March 2021