REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Oxfordshire County Council - [redacted], Chief Executive**
1	**CORONER** I am Mr D M Salter, Senior Coroner, for the Coroner area of Oxfordshire
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 30 July 2020 I opened an inquest into the death of David Lewis. The inquest concluded on 14 January 2021 with a hearing at Oxford Coroners Court. Mr Lewis was 60 years old when he died at the scene of a road traffic accident at Vendee Drive, Bicester. The conclusion of the inquest was 'Road Traffic Collision' with the following factual findings: *At approximately 22.05 on 16 July 2020 David Lewis was driving north from junction 9 of the M40 motorway towards Bicester on the A41 when he overshot the roundabout at Vendee Drive at speed causing his vehicle to become air borne and land upside down. He sustained a head injury and died at the scene.* I heard evidence from three witnesses at inquest along with other written statements and reports. One of the witnesses who gave oral evidence was [redacted], Group Manager, Area Operations, Highways, at Oxfordshire County Council. The other two were [redacted] of Hampshire and Thames Valley Joint Roads Policing and [redacted], Police Collision Investigator. I attach copies of their statements and reports for your information.
4	**CIRCUMSTANCES OF THE DEATH** Mr Lewis was driving his vehicle on 16 July 2020 when he overshot the roundabout at Vendee Drive, Bicester at speed. It appears that he failed to detect the presence of the roundabout on his approach. It is noteworthy that he was intoxicated with alcohol and was $1^1/_2$ times the legal limit for driving. However, it will be noted from pages 6 & 7 of Mr Croxton's report that there is a significant history of very similar accidents with cars overshooting this roundabout, this includes a double fatality on 12 June 2019.
5	**<u>CORONER'S CONCERNS</u>** I note and understand there have been audits and studies at this location and there have been improvements on signage, reduced speed limits on approach and more recently enforcement with cameras. Notwithstanding, there is a reason for continued concern. 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 action is taken. In the circumstances it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows. – (1) It will be seen from paragraph 18 of [redacted] statement that a few days after this tragic accident there were amendments in the form of a reduction in the speed limit on approach to the roundabout. I understand these amendments were likely to be the result of a review which took place after a double fatality in June 2019. I am concerned that despite improved signage and reduced speed limits there is still the danger of drivers not noticing the roundabout in sufficient time. Importantly, it is noticed that the roundabout is approached from around a bend or deflection. It appears that more may be required in terms of engineering. One possibility that was mentioned by [redacted] was that consideration could be given to rumble strips/bars on the road surface which could give drivers an auditory warning in addition to visual warning. It is not for me to make a recommendation, but I do have a duty to request a review and response. I will be interested to learn if the addition of rumble strips/bars or any other engineering improvements might be considered with a view to reducing the prospect of any similar incident in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 16 April 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 family. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	 **19/02/2021**