Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:
The Rt Hon Grant Shapps, Secretary of State for Transport,
Department for Transport
Great Minster House
33 Horseferry Road
London, SW1P 4DR

1 CORONER

I am Peter NIETO, Area Coroner for the area of Derby and Derbyshire

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 10/12/2018 I commenced an investigation into the death of Heike MOJAY-SINCLARE aged 29. The investigation concluded at the end of the inquest on 16 September 2021. The conclusion of the inquest was:

I a Drowning

I b

I c

II

4 CIRCUMSTANCES OF THE DEATH

Heike Mojay-Sinclare died on 9 December 2018 due to drowning when her car became stuck in high and rising flood water at a ford on Doles Lane near Ashbourne in Derbyshire. She had been travelling on 8 December 2018 from her home in Hertfordshire to stay at a Peak District cottage for a friend's birthday celebration.

It is not known why she was travelling on Doles Lane , having joined it at its junction with the A515, as the lane is a single carriage road, essentially an access road, and would not feature on a recommended route plan. She will not have been familiar with the lane.

There was very high rainfall at the time Heike was in the vicinity of Doles Lane. A brook, classed as a river, crosses the lane and had flooded. The responsible local authority had installed ford warning signs on the lane and signs stating that it is unsuitable for motor vehicles. From Heike's comments to emergency services in a call from her car when in the water it appears she had noticed a ford sign.

The ford has a depth gauge of two metres height cited in the usual course of the water but due to the extreme rise in water level it may not have been visible to Heike. The depth gauge had been installed by the local authority on account of a previous serious incident and concerns raised by residents and the parish council. It is not clear that the local authority was aware of a number of other previous incidents at the ford about which the inquest heard some details and those incidents

may not have been shared by relevant agencies. The inquest was told that depth gauge requirements for fords currently lie outside of the regulatory regime for highways.

As has been stated it is not clear why Heike was travelling on the lane. The driving conditions will have been very bad and it is unlikely that she will have appreciated the danger when she entered the ford in her car or the potential depth of the water. The water rose fast inside her car and she was very concerned with saving her two dogs in the rear of the car. The indication from the transcript of the call to emergency services is that she climbed through into the rear of the car to see to her dogs and then became stuck.

Given the time of the sudden ending of Heike's call to emergency services an effective rescue was impossible.

Heike was pronounced dead when she was recovered from the water on the morning of 9 December 2018 but it is clear that she will have died during the late evening of 8 December 2018.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

1. The inquest heard that with regard to water depth gauges, specifically for river fords, the Traffic Signs and General Directions 2016 removed prescription of the type of signs to be used and the requirement for their use at river ford crossings. Those requirements were in the previous 2002 Directions. There s relevant guidance (Ch.4 Traffic Signs Manual) but this is not mandatory and leaves enactment to the discretion of the relevant local authority. As water depth gauges are outside of the regulatory regime there may be fords without gauges, or where they are installed they may be sub-optimal and deficient. There is also lack of clarity for local authorities and the lack of a prescribed design and standard means that manufacturers do not have an approved design to work to and provide to local authorities.

2. The inquest heard that river fords and depth gauges do not currently lie within mandatory highways inspection requirements and therefore there is no guarantee of their maintenance and review, and therefore no guarantee that they continue to provide on-going usability and safety.

3. The inquest heard that there were a number of previous serious incidents which it appears were not notified to the relevant local authority, and that if they had been there would likely have been a review of measures relating to the river ford. A mandatory requirement for inter-agency information sharing in these circumstances is indicated.

Please note that these concerns are raised within the context of what appear to be increasingly frequent severe rainfall and flooding events.

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 12 November 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

1. [redacted]

2. Derbyshire County Council

I have also sent it to

1. Derbyshire Fire and Rescue Service

2. Derbyshire Police

who may find it useful or of interest.

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

Peter NIETO
Area Coroner for
Derby and Derbyshire
Dated: 17 September 2021