HM CORONER
Central Lincolnshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Director of Highways, Lincolnshire County Council**
1.	**CORONER** I am Paul Duncan Smith, Assistant Coroner, for the coroner area of Central Lincolnshire, Lindum House, 10 Queen Street, Spilsby, Lincolnshire, PE23 5JE.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3.	**INVESTIGATION and INQUEST** On 30 March 2015 I commenced an investigation into the death of Joan Lilian Green, aged 77. The investigation concluded at the end of the inquest on 20 October 2016. The conclusion of the inquest was that Mrs Green died as a result of a road traffic collision, the medical cause of death being: 1a. Multiple Injuries
4.	**CIRCUMSTANCES OF THE DEATH** 1 On the 21 March 2015 at approximately 1.00pm Mrs Green was the front seat passenger in an Audi A1 saloon car registered number [redacted]. That vehicle was being driven northbound up the A1 Great North Road near the village of Marston, Lincolnshire. The vehicle was being driven by her daughter [redacted] The road comprised a dual carriageway carrying two lanes of traffic in each direction. The National Speed Limit applied to both North and Southbound carriageways. 2 The Audi reached the junction with Toll Bar Road, leading to the village of Marston, which lay to the East. It was the driver's intention to leave the A1 at that junction , and the vehicle waited in a designated right turn lane, situated to the extreme right hand side of the Northbound dual carriageway, before the driver began to make her turn through a break in the central reservation. 3 The Audi was required to turn across both lanes of the Southbound A1 to reach Toll Bar Road. As it did so it was struck by an HGV travelling in lane 2 of the Southbound carriageway. There was a heavy impact. Mrs Green was killed and her daughter received very severe injuries.
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. – (I) I received evidence that there were no identifiable defects with the junction. Visibility was good, and all signage and road markings, although a little worn, were said to be clear and unambiguous. (II) I received evidence that although the HGV involved was travelling at 56mph, which was marginally above the maximum permitted speed for that class of vehicle at that time, the limit had since been increased to 60mph on 6 April 2015 and that the additional speed made little or no difference to the circumstances of this collision. (III) I received evidence that in order to assess the likely time taken by the Audi to cross the junction, in the days following this incident, the investigating officer carried out covert surveillance at the junction. During the period of that surveillance, of approximately one hour, he recorded one "near miss" in circumstances identical to the index accident and two further "near miss" incidents. The officer also reported that he observed an HGV waiting for a period of in excess of six minutes prior being able to turn safely across southbound traffic into Toll Bar Road. (IV) I received evidence that whilst there were no defects with the road which could be classed as contributory to this collision, the nature of the junction may have been a contributory factor. It was described as "challenging". I was told that since 1985 there had been 4 other fatal road traffic collisions at this junction, two of which involved vehicles turning across Southbound traffic.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation has 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 23 December 2016. 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 [redacted] 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.
	24 October 2016 ..... **P D Smith** **Assistant Coroner**