ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. David Bowe**
1	**CORONER** I am Robert Turnbull, senior coroner, for the coroner area of North Yorkshire Western Area
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 18th September, 2012, I opened an inquest touching the death of William David McCourt, then aged 52 years. The inquest was concluded on 12th December, 2013. The conclusion of the inquest was that Mr McCourt died from injuries sustained in a road traffic collision, the medical cause of death being severe head injuries.
4	**CIRCUMSTANCES OF THE DEATH** 1) On the afternoon of the 15th September, 2012, Mr McCourt was riding his motorcycle on the A6108 Reeth to Richmond road. It was a fine day with good visibility. The motorcycle was being ridden at a speed appropriate to the road conditions and within the speed limit. 2) On approaching a location known as Lowenthwaite Bridge Mr McCourt was confronted with a patch of running water which was running across the road from adjacent land. He lost control of his motorcycle and was thrown from it sustaining injuries from which he died at the scene. 3) There had been a flood warning sign erected to warn motorists of the presence of the water. However, the sign had fallen over some time previously and would not have signalled a warning to Mr McCourt. 4) Evidence at the inquest established that the hazard created by this running water was a long standing problem and had been present almost continuously since December, 2011. In February, 2012, it was reported by a local resident to the Highways authority via their website. Another resident had contacted the Highways authority by telephone on two occasions, on the second occasion, in May, 2012, he was told that somebody would come out to investigate but heard nothing more. 5) In June, 2012, a two car accident occurred at the same location. On this occasion a Highways Maintenance Manager attended and spoke to people at the scene. Flood signs were erected and enquiries commenced to establish who owned the land and to require action to be taken to resolve the matter. It appears that the maintenance manager believed that the land in question was under the control of the Ministry of Defence. There was no written record of what had been said on that occasion. 6) Between June, 2012, and the date of this accident there were numerous telephone contacts between the maintenance manager and representatives of the Ministry of Defence but nothing was resolved. It was after this accident on 15th September, 2012, that the Ministry of Defence finally stated that they did not own the land in question. Over that period nothing had been sent to the Ministry of Defence in writing requiring them to confirm ownership. This water continued to run across the road, even in dry periods, between June and September, 2012, with no action taken to resolve the problem other than the erection of

	signs. 7) This road was subject to monthly inspections. The inspection reports did not mention the water on the road. 8) The matter was finally resolved following the accident when a police officer visited the owner of the land and action was taken to clear a blocked drain.
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. – 1) No record was found of the reports made by local residents prior to June, 2012, of flooding at this location either via the Highways website or by telephone on two occasions and, therefore, no action taken. 2) The maintenance manager who visited the site in June, 2012, formed the opinion that the land in question was owned by the Ministry of Defence. There is no note of the conversation which led to this conclusion, neither did the maintenance manager visit the occupier of the land from which the water was flowing. 3) Over a three month period nothing was done to address the issue other than to telephone the Ministry of Defence. The Ministry of Defence did not provide an answer to the question of ownership of the land until after this accident when they confirmed that they were not responsible for the land in question. 4) Nothing was ever put in writing to the Ministry of Defence requiring them to notify the Highways Authority within a reasonable time scale as to whether they owned the land and if so what action would be taken and by when. 5) This situation was allowed to 'drift' over at least a 3 month period prior to the accident. 6) Inspectors should have reported all potential hazards and actions taken to address them.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [and 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 14th January, 2014. 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], Fentons Solicitors, North Yorkshire County Council Legal Department and [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.
9	**14th January 2014** **Robert Turnbull** **Senior Coroner North Yorkshire Western Area**