HM CORONER
Central Lincolnshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Steve Willis, Chief Operating Officer, Lincolnshire County Council**
1.	**CORONER** I am Stuart P G Fisher, Senior 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 22nd September 2014 I commenced an investigation into the death of Joshua David Booth, Aged 22 years. The investigation concluded at the end of the inquest on 11th March 2015. The conclusion of the inquest was that Mr Booth died as a result of a Road Traffic Collision, the medical cause of death being: 1a. Multiple Injuries
4.	**CIRCUMSTANCES OF THE DEATH** On 14th September 2014, Mr Booth was travelling westbound along a road which runs parallel with Fodder Drain. When he was approxiametely 275 metres east of Hobhole Drain he drove over a heavily subsided section of road which, in part, caused him to lose control of his Peugeot 206 Motor Vehicle resulting in him leaving the road to his offside, following which the vehicle collided with a wooden post at the foot of the bank and somersaulted into Fodder Drain. Mr Booth sustained fatal injuries. Full details of the incident and investigation are set out in Police Constable Holloway's report, a copy of which has been made available to Officers of your department.
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) The subsided section of road is seriously substandard and a danger to passing motorists and formed a contributory factor to Mr Booth's death. The section of road requires immediate repair. (II) Appropriate signage needs to be erected to warn of the imminent danger of the road subsidence. The signage needs to be closer to the section of road in question and should include an appropriate advisory speed limit.

	(III) The posts at the foot of the bank constitute a serious danger to vehicles leaving this section of road. An Armco barrier should be erected along this section of the road to provide security to passing motorists.
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 11th May 2015. 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 (a) [redacted] (b) 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.
	16 March 2015 ..... **S P G Fisher** **Senior Coroner**