

# A R W Forrest LLM, FRCP, FRCPath GMC Number: 1333523 Her Majesty's Senior Coroner for South Lincolnshire

## **REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: The Rt Hon Patrick McLoughlin MP
	Secretary of State for Transport
	1.
1	CORONER
	I am ARW Forrest, Senior Coroner for the Coroner's area of South Lincolnshire.
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 28 <sup>th</sup> May 2015 I commenced an investigation into the death of Sheila Slater, Age 81.
	The investigation concluded at the end of the inquest on 30 <sup>th</sup> March 2016. The
	conclusion of the inquest was Road Traffic Collision
4	CIRCUMSTANCES OF THE DEATH
	Sheila Slater was the front seat passenger in a car driven by her husband. They were
	driving north along the A16 near Crowland. On reaching the staggered junction with the
	B1166, he manoeuvred into the Central reservation with the intention of turning right into
	The B1166 and continued into the path of an oncoming South bound vehicle travelling on
	the A16. Mrs Slater died at the scene of the subsequent collision.
5	CORONER'S CONCERNS



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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. -

The staggered junction of the A16 with the B1166 is part of the Crowland Bypass which was opened in 2010. As with all of the other staggered junctions in Lincolnshire it was built to DFT specifications. Since it was opened there have been 3 fatalities associated with this junction (2 at the junction and one on the approach to the south bound island) and 10 injury producing collisions. There have been fatalities at the other staggered junctions in Lincolnshire. DFT and Highways England have been made aware of the problems associated with these junctions both by S.28 reports and correspondence from officers of Lincolnshire County Council. At the inquest, into Mrs Slater's death evidence was given to the effect that this particular junction could be made safer if it were to be replaced by a roundabout but that local funding was not available for this purpose. Witnesses also were concerned about the safety record of other staggered junctions in Lincolnshire.

### 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, particularly given that these junctions have been built to DFT specifications.

### 7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 27 May 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



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# Persons: 1. 2. Road Safety (Accident Investigation) Manager, Lincolnshire Road Safety Partnership. 3. Paul Cooper (Acting Senior Coroner, South Lincolnshire, wef 1 April 2016) 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.

**H M Senior Coroner for South Lincolnshire** 

ARW Forrest.....