REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **This report is being sent to:** **1. The Chief Executive, Sheffield City Council** **2. The Chief Constable, South Yorkshire Police** **3. The Chief Executive, Amey PLC** **4. The Chief Executive, Yorkshire Water PLC**
1	**CORONER** Christopher P Dorries OBE, HM Senior Coroner for South Yorkshire (West)
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** In December 2015 I commenced an investigation into the death of Mr Sean Craig Salvin. The investigation concluded following an inquest in February 2016 where the narrative conclusion set out that: *Sean Craig Salvin died on 30th December 2015 in consequence of severe injuries sustained when his car left the road in the area of Sheffield known as Woolley Wood Bottom. The road was heavily flooded at the time (a period of very heavy rainfall) primarily because of a long standing under-capacity of the sewers, albeit possibly with more recent blockages. Because of failures to collect, share and collate information, opportunities had been missed during the month of December 2015 for authorities to recognise that there was an increasing problem of flooding at that location. Thus no remedial measures were taken which could have avoided the incident in which Mr Salvin lost his life.*
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are set out in the narrative conclusion shown above. In short, the evidence showed that whilst individual authorities had taken some actions on some issues that they became aware of there was a lack of co-ordination in the collection and collation of information between those authorities. This meant that the wider picture of an increasing problem at the location was never fully appreciated.

CORONER'S CONCERN

During the course of the investigation my inquiries revealed matters giving rise to a 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 --

a) The evidence showed that there was insufficient system for the collation and sharing of information to assure that each of the authorities was aware of potentially important incidents. If national guidelines were being followed, as was stated, then the evidence suggests that those guidelines are themselves deficient.

b) In particular, such sharing of information as there was did not always fully or even properly identify the location concerned. The inquest showed that it was not difficult to identify that a number of incidents had occurred in the same place prior to the fatal collision.

c) Further, the system did not apparently require 'damage only' incidents to be shared. It is appreciated that the sharing of minor incidents could easily become burdensome but the case of [redacted] (August 2015) which was recorded as 'damage only' was actually a serious matter indicating that greater care is needed in the collection/sharing of information and subsequent categorisation.

d) [redacted] had suffered unpleasant injuries including a fractures to his lower back. Although this became known to the South Yorkshire Police, no adjustment was made. Amey advised the court that they had not been made aware of this incident.

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e) The risk assessment of this location was also of concern to the inquest, both in respect of prioritisation of funding for major work and in terms of the recognition of the degree of risk. This was a location where traffic might be expected to be travelling comparatively quickly with the major hazard of trees immediately adjoining the carriageway. The emergence of a propensity to flood was a most important addition to the risk calculation.

f) Whilst it is recognised that steps have been taken which are believed to remove or significantly reduce future risk at this location, the authorities may wish to consider continued close monitoring until they can be sure that this is the case.

g) Witnesses reported the street lighting as 'adequate' and a site inspection did not suggest otherwise. However, the growth of trees and the development of leaves in Spring and Summer will inevitably reduce the lighting available on the road unless proper (and probably substantial) trimming takes place. The court was told that this is a recognised and regular maintenance issue but a concern would arise if this was reduced for any reason such as future budgetary constraints.

h) Finally, and not a matter of risk to the public, the court noted that a timing submitted by Messrs Amey was significantly different to a time provided by South Yorkshire Police which the court accepted as accurate. It was explained that the timing came from a computer and there is no reason to suggest that it was put forward in anything other than good faith. The matter became irrelevant to the inquest – but that might not always be the case and Amey may wish to review the technical aspects of the timing to prevent future difficulties.

I therefore make this report.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, the named authorities, 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 31st May 2017. I may extend this period upon request. 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 family of Mr Salvin. 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.

Christopher P Dorries OBE

4th April 2017