Ms N J Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Head of Service, Doncaster MBC, Highways, Regeneration and Environment, Civic Building, Waterdale, Doncaster
1	**CORONER** I am Ms N J Mundy, Senior Coroner for South Yorkshire (East District)
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 09/01/2017 I commenced an investigation into the death of Ellie Jay Chappell, 21. The investigation concluded at the end of the inquest on 14 June 2017. The conclusion of the inquest was Road Traffic Collision. Ellie Jay Chappell died on A614 Selby Road on 2nd January 2017 after hitting a patch of ice whilst driving her motor vehicle which led to loss of control of her vehicle. The resultant collision led to catastrophic injuries and her immediate death from multiple traumatic head injuries
4	**CIRCUMSTANCES OF THE DEATH** Ellie Chappell was travelling along the A614 on the morning of the 2nd January 2017 at a moderate speed well within the prescribed speed limit for that stretch of carriageway. During the course of negotiating a right-hand bend with a reduced speed commensurate with the icy road conditions, her vehicle struck a patch of ice causing her vehicle to rotate after which followed over correction of steering causing her to present the offside of her vehicle to a vehicle travelling in the opposite direction. She sustained extensive injuries with death being confirmed at the scene. During the course of the hearing I received evidence from [redacted] of South Yorkshire Police who had investigated this matter. Part of his investigation included obtaining data on previous accidents on that stretch of carriageway and [redacted] informed me that since 2011 there had been 14 collisions on that stretch of road, four of which included serious injury. Two of those were on the same bend where Miss Chappell lost control and both these had slippery road as a factor. Of the others, [redacted] informed me that five of those recorded incidents had slippery roads as a factor. He also described to me the location as having the road sheltered to an extent by surrounding bushes and trees before opening out into an unsheltered area which would be more prone to ice on the road. Given this information and in particular the statistics available from 2011, the absence of any warning of any slippery conditions on the stretch of carriageway and wintery conditions was of some concern. [redacted] informed me that there are steps that can be taken to warn drivers of such impending hazards.
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) Given the number of road traffic incidents on this stretch of road and the proportion which recorded the slippery road as being a factor, I am concerned that the absence of any warning signs in this vicinity will put drivers at risk of incidents and death in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [redacted] 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 09 August 2017. 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.
9	Dated 14 June 2017 Signature_____ Senior Coroner for South Yorkshire (East District)

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