REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: , Programmes Delivery Engineer for Warwickshire County Council. CORONER I am John Joseph Buckley, Assistant Coroner for the Coroner Area of Warwickshire.
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.
 INVESTIGATION and INQUEST On 5th January 2016 I commenced an investigation into the death of Katherine Tracey Vanloo, then aged 52 years. The investigation concluded at the end of the inquest on 28th September 2017. The conclusion of the inquest was a narrative conclusion. The medical cause of death was 1a lung lacerations, splenic lacerations, fractured skull and left forearm b road traffic collision The pothole on Napton Holt Road in Warwickshire into which Mrs Vanloo fell when riding her bicycle was first indentified on 23rd March 2015 as a category 2 defect by a Safety Inspector employed by Balfour Beatty Living Places. Under the terms of the Warwickshire County Council Highways Maintenance Safety Inspections Manual to which Balfour Beatty Living Places was working there was a target of 28 days within which such category 2 defects should be repaired. The works order to carry out the repair was raised by Warwickshire County Council three months later on 5th June 2015 and received by Balfour Beatty Living Places on 10th June 2015. The pothole was first identified on 23rd March 2015 and an employee of CR MacDonald Limited, to whom Balfour Beatty had subcontracted the road repair work, was sent out for the first time on 2nd November 2015 to repair the pothole, albeit that the wrong pothole was in fact repaired.

4	CIRCUMSTANCES OF THE DEATH
	Katherine Tracey Vanloo died on 3 rd January 2016 near to the entrance to Headlands farm on Napton Holt Road Warwickshire from catastrophic injuries she sustained in a collision with a Toyota Yaris car. Mrs Vanloo was cycling with a friend at the time and was thrown from her bicycle into the path of the car when her bicycle hit an unrepaired pothole in the road. She was pronounced dead at the scene at 1101am.
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 could 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) The pothole was first identified on 23 rd March 2015 as a category 2 defect with a target of 28 days within which such defects should be repaired.
	(2) The works order to carry out the repair was only raised by Warwickshire County Council 3 months later on 5 th June 2015. This was sent to Balfour Beatty Living Places who had entered into a contract with Warwickshire County Council to repair road surfaces in Warwickshire. They in turn subcontracted the road repair work, which included pothole repair work, to CR MacDonald. The works order was received by CR MacDonald on 19 th June 2015.
	(3) The work to repair the pothole was not undertaken by an employee of CR MacDonald until 2 nd November 2015, albeit that the wrong pothole was repaired on that day.
	(4) There was a delay of over 7 months between the identification of the pothole and the time it was supposedly repaired on 2^{nd} November 2015.
	(5) At the time of the incident Warwickshire County Council did not have a system in place to track with Balfour Beatty Living Places or CR MacDonald the progress of works orders, i.e. when outstanding works had been completed, nor any formal programme of auditing to check if the work has been done and to check the quality of the work.
6	ACTION SHOULD BE TAKEN
	In my opinion urgent action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
	The action should include an explanation of the steps you have taken to speed up the time it takes to repair potholes once they have been identified and what steps you have taken to track the progress of work orders that have been sent to Balfour Beatty Living places for 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 23 rd November 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, to Mrs Vanloo's parents and sister, Balfour Beatty Living Places and CR MacDonald.

I am 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 DATE of REPORT

28th September 2017

John Joseph Buckley, Assistant Coroner

