	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] General Counsel Highways England**
1	**CORONER** I am Patricia Harding, senior coroner, for the coroner area of Mid Kent & Medway
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** On 11th July 2014 I commenced an investigation into the death of Deborah Roberts, 42 years and Marshall Roberts 8 years. The investigation has not yet concluded and the inquest has not yet been heard.
4	**CIRCUMSTANCES OF THE DEATH** Deborah Roberts was driving her two sons south on the Sheppey Crossing road bridge in her Renault Clio shortly before 13.30 on 1st July 2014 when she had cause to stop her car in the left lane of the two lane carriageway (the information presently available suggests that the bonnet of her car may have been insecure and lifted). There is no hard shoulder or safety lane on the road bridge. Whilst her car was stationary it was struck by a Fiat Ducato van which was travelling in the same direction in the same lane. Deborah Roberts was thrown from the vehicle and died. Her son, Marshall who was in the offside rear seat at the time of the collision was also killed.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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. – • Accident data reveals that in addition to the collision subject of this inquest which resulted in two fatalities, there have been a number of rear end collisions on the Sheppey Road Bridge associated with stationary vehicles being struck including a multiple vehicle collision in September 2013 • A review of the safety of the Sheppey Road Bridge published in February 2015 has concluded that a combination of the geometry of the bridge affecting the forward visibility available to drivers and the high speeds of vehicles travelling over the bridge which has a 70 mph limit impacts on the safety of the bridge. The review recommended a reduction in the speed limit to 50 mph to mitigate the safety concerns • The speed limit for the bridge remains at 70 mph
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe your organisation has 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 7th August 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: Chief Constable of Kent Police, [redacted]s (father of Marshall Roberts) [redacted] (sister of Deborah Roberts) BLM Law representing [redacted] (driver of vehicle involved in collision and to the Local Safeguarding Board as Marshall Roberts was under 18. I have also sent it to Gordon Henderson MP for Sittingbourne & Sheppey who may find it useful or of interest. 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	**11th June 2015** **SENIOR CORONER**