

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

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Chief Executive - Warwickshire County Council CORONER I am S McGovern, senior coroner, for the coroner area of Warwickshire 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. INVESTIGATION and INQUEST 3 On 22 February 2018 I commenced an investigation into the deaths of Laila Habibi and her son Daniel Ghafuri (aged 2 years) The investigation concluded at the end of their inquests on 13 September 2018. The conclusions of the inquests was that both had died as a result of Road Traffic Collision. **CIRCUMSTANCES OF THE DEATH** On 17 February 2018 at approximately 10.30pm, Mrs Habibi and her son were killed on A426 Lutterworth Road, Rugby, Warwickshire. They were both passengers in a car which had been diverted off the M1 motorway shortly before the collision, The driver believed in was on a dual carriageway and as a result was in the wrong carriageway and was struck by an oncoming HGV vehicle. Both Mrs Habibi and her son died at the scene. 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) that there had been a number of road traffic incidents on this road including fatalities, (2) that this road is a regular diversion route from the M1 motorway hence periodically, receives usually large volumes of traffic (3) an absence of an illuminated 'single carriageway' warning sign **ACTION SHOULD BE TAKEN** 6



In my opinion action should be taken to prevent future deaths and I believe you as Chief Executive of Warwickshire County Council 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 8th November 2018. 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.

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 13th September 2018 Senior Coroner S McGovern