IN THE WEST YORKSHIRE WESTERN CORONER'S COURT

IN THE MATTER OF:

The Inquests Touching the Death of Danielle Lea Broadhead

A Regulation Report – Action to Prevent Future Deaths

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Director of Roads and Highways, Kirklees Council

1 CORONER

Martin Fleming HM Senior Coroner for West Yorkshire (Western) Coroner Area

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 and INQUEST

On Twenty-Seventh April 2020 I commenced an investigation into the death of Danielle Lea BROADHEAD aged 33. The investigation concluded at the end of the inquest on Thirty-First March 2021.

I found that the cause of death to be: -
1a. Traumatic brain injury

I arrived at a conclusion of road traffic collision

4 CIRCUMSTANCES OF THE DEATH

On 20 April 2020 Danielle Lea Broadhead lost control of her motor vehicle as she drove along Barnsley Road (A637), Flocton after clipping a kerb at a location where the grass verge ends and becomes a pedestrian pavement on the apex of a left sweeping bend in the road. As a result she tragically collided with a tree. Although Danielle received fatal head injuries, her two accompanying children survived.

5 CORONER'S CONCERNS

Given that Danielle appears to have inadvertently clipped the kerb -
The MATTER OF CONCERN is as follows. –

- To review and consider the existing road layout to ensure that it meets the correct regulations and standards.
- To consider the appropriateness of measures which highlight the commencement of the kerb to oncoming motorists.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that Kirklees Council 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 10 June 2021. 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] – Danielle's mother
- [redacted] – Forensic Collision Investigator

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.

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M D FLEMING
HM Senior Coroner for
West Yorkshire Western Coroner Area

Dated: 15 April 2021