REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Senior Engineer, Traffic Engineering North Yorkshire County Council ("the Highway Authority") of County Hall, Racecourse Lane, Northallerton, N.Yorkshire**
1	**CORONER** I am John Nigel BROADBRIDGE assistant coroner, for the coroner area of North Yorkshire and York including North Yorkshire Western 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.
3	**INVESTIGATION and INQUEST** On 21 January 2021 an investigation commenced into the death of Sasha- Raven Marie Brown aged 21 years. The investigation concluded at the end of the inquest on 16 February 2022. The conclusion of the inquest was that Miss Brown died because of multiple major injuries due to a Road Traffic Collision. A formal Conclusion of Road Traffic Collision was recorded.
4	**CIRCUMSTANCES OF THE DEATH** On 19 January 2021 Miss Brown was the unaccompanied driver of a motor car on the A6068 between Cowling and Glusburn travelling down an incline where the road surface was very wet due to heavy falls of rain. She lost control of the vehicle in the wet conditions and came into collision with an oncoming car. She suffered serious injuries in that collision from which she was recognised as deceased there at 12.49 hours that same afternoon.
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. – It is acknowledged that officers of the Highway Authority were not called to give evidence at the Inquest Hearing nor was the Authority designated as an Interested Person for the purposes of disclosure and participation at the Hearing. There had been a written Report Collision ref 01-21 however from the Authority received at the Hearing

	relating to the roadway being the "A6068 Colne Road between Carr Head Lane and New Hall Farm near Cowling/Crosshills, Craven District" However the evidence revealed: a) The particular stretch of the A6068 was known to local, and other motorists familiar with it, as being frequently incapable of adequately and safely clearing surface storm and rainwater off the carriageway surface, thereby to make the road as reasonably safe as possible for the passage of motor vehicles, especially those travelling down the incline (as was the deceased). b) That water flowed and flows rapidly down the incline. It was (and is) is not adequately regulated by drains and did not (and does not) get away. Instead water which came off (and comes off) adjacent land as well as the road itself accumulated (and accumulates) in volume. The want of appropriate cambers and slopes across the carriageway allowed (and allows) and indeed encouraged (and encourages) the water flow across the whole of the carriageway, rather than be conducted along drainage channels to the sides of the carriageway. c) The profile of the roadway meant (and means) that the water was (and is likely to be) thrown back (and forth) across the carriageway The evidence showed a heavy water flow spread right across the carriageway into the deceased's path from the deceased's offside to nearside. That had been from an accumulation of water after there was a flow nearside to offside a short distance back from the incident scene. d) The process of simply cleaning out drains was not (and has not been) adequate to minimise the risk to road users. The evidence pointed to the need to make significant permanent road engineering alterations to the camber, layout, profile and slopes of the road surface and drains. The evidence indicated that the high levels of traversing water were not rare occurrences, creating what was found to be a 'notoriety'. Climate change will increase the likelihood of adverse incidents such as was evidenced happening in the future, causing increased risk of death. The roadway here will remain a high risk, as it was for the deceased, for fatal accidents. e) There were (and are) no signs/signage indicating the risk of the road 'flooding', whether temporary or permanent at this location. Those familiar with it, including the Police expert, knew it for the past and present risk of loss of control. That should not mean the risk can be acceptable. f) The Authority must consider promptly permanent road engineering solutions and implement those appropriate to make this road as safe as reasonably possible.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 Friday 22 April 2022. 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], Mother of Miss Brown I have also sent it to Chief Constable, North Yorkshire Police, Alverton Court, Crosby Road, Northallerton, DL6 1BF 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	18 **February 2022** **SIGNED BY** JNBroadbridge