REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **The Asset, Policy and Commissioning Manager,** **Suffolk Highways,** **3 Goddard Road,** **Ipswich,** **IP1 5NP** [redacted] **General Manager** **Kier Highways Ltd** **3 Goddard Road,** **Ipswich,** **IP1 5NP**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 7th September 2021 I commenced an investigation into the tragic death of **Stephen John COOMBES** The investigation concluded at the end of the inquest on 22nd July 2022. The conclusion of the inquest was that:- **Stephen 'John' Coombes died on the 3rd September 2021, at the Addenbrookes Hospital, in Cambridge.** **John had been admitted to the Addenbrookes Hospital on the 29th August 2021 following a single vehicle road traffic collision on the A1101, Burnt Fen, near Mildenhall in Suffolk.** **Immediately after the road traffic collision, John was trapped upside down in his vehicle, and initially could not be extracted from it. Due to the position he was in, John's airway was closed, inducing postural asphyxia.** The medical cause of death was confirmed as: **1a Complications arising from traumatic and hypoxic-ischaemic brain injury** **1b Head injury in association with postural asphyxia.**
4	**CIRCUMSTANCES OF THE DEATH** Stephen 'John' Coombes died on the 3rd September 2021, at the Addenbrookes Hospital, in Cambridge.

	John had been admitted to the Addenbrookes Hospital on the 29th August 2021 following a single vehicle road traffic collision on the A1101, Burnt Fen, near Mildenhall in Suffolk. The convertible Porsche John was driving left the road and came to rest upside down in a ditch. John was originally trapped in the upside-down car pinned to the ground. Attending police officers and ambulance crew were able to release John and extricate him from the vehicle. John was taken to Addenbrookes, but due to the injuries he had received, he continued to deteriorate until he passed away on the 3rd September 2021. Subsequent police investigation identified that a deep depression in the road surface contributed to John losing control of the vehicle he was driving. This depression was known to be present by the Highways authority, and a temporary 30 mph speed limit (instead of the usual 50mph) had been put in place. Inadequate road signage, did not reflect the temporary 30mph limit and John hit the depression at approximately 50mph, his vehicle being forced off the road as a result. Had John known to negotiate the depression at 30 mph, this tragic incident would not have occurred.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters given 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** as follows. – The court heard that the depression was known to be present by the Highways Authority, and a temporary 30 mph speed limit (instead of the usual 50mph) had been put in place. Evidence was heard from the Forensic Crash Investigation Officer from Suffolk Constabulary, who conducted an investigation into the road traffic collision which caused John's death. This officer told the court, how he and a colleague drove a police vehicle over the depression in the road at various speeds to observe the reaction the vehicle had to damaged road surface. At 30 mph the police vehicle negotiated the depression in the road with relative ease. At 50 mph, the police vehicle reacted significantly when negotiating the depression. At the time of Johns collision, he had just overtaken another vehicle and therefore crossed the depression a slight angle as he returned to his own side of the carriage way. When the police officers replicated this vehicle movement at 50 mph, the police vehicle reacted violently, with one of the rear wheels leaving the surface of the road. The officer driving that vehicle was not prepared to attempt the same manoeuvre at any higher speed due to the risk involved.

	The police officer then told the court that the attending officers themselves were unaware of 30 mph speed limit on this stretch of road. The officer told the court that the main 50 mph signs, the smaller repeater 50 mph signs and the 50 mph roundels painted on the road surface were all clearly visible on this stretch of road. Prior to the depression the officer saw one temporary 30mph partially obscured in the verge, but assumed it was left over from previous works, as all of the 50mph signs remained in view. Evidence was heard that in the normal course of events, when a temporary reduction in a speed limit is imposed on a stretch of road, any signage indicating a higher speed limit should be covered by either securing a dark bag or sack over the sign, or spray painting it out. On the basis of the police officers' evidence, that clearly did not occur in this case, and this, coupled to there being only one 30mph temporary sign in place prior to the depression in the road, left road users (and attending police officers) unaware of the reduced speed limit in place. I am therefore concerned that should further identified road defects require a reduction in the speed limit, that any repeat of the provision of inadequate signage and/or a failure obscure higher speed limits may result in further fatalities.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th September 2022 I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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;- 1. John's next of kin. 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**25th July 2022** **Nigel Parsley**