**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. North Lincolnshire Council** |
| 1 | **CORONER**<br><br>I am Paul Duncan Smith, acting senior coroner, for the coroner area of North Lincolnshire and Grimsby |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br><br>Coroners and Justice Act 2009 (legislation.gov.uk)<br>The Coroners (Investigations) Regulations 2013 (legislation.gov.uk) |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 25 May 2021 I commenced an investigation into the death of Adam David Simms (dob 07/09/02). The investigation concluded at the end of the inquest on 7 October 2022. The conclusion of the inquest was that Mr Simms died as a consequence of multiple injuries sustained in a road traffic collision which occurred on 21 May 2021. The formal conclusion was Road Traffic Collision. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On 21 May 2021 at around 09.00 a.m. Mr Simms was the driver and sole occupant of his Hyundai i30 motor car [redacted] which was travelling east out of Scunthorpe on the A18 road known locally as Mortal Ash Hill. The road comprised a section of dual carriageway which climbed a slight uphill gradient before transitioning into a single carriageway and commencing a slight downhill gradient. It had been raining heavily for some time. At the point at which the dual carriageway ended Mr Simms' vehicle struck a large patch of water lying upon the carriageway. As a result of that hazard, he lost control of his vehicle and crossed onto the west bound carriageway where he collided with an oncoming lorry, sustaining fatal injuries. It was likely that Mr Simms was travelling too quickly for the weather conditions. Further, his vehicle was found to have insufficient tread to the offside front tyre. Those were contributory factors to his loss of control. |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. – |

(1) I received evidence regarding the system of inspection utilised to identify and remedy any blocked drainage gullies. Two blocked gullies were found at the site of the accumulation of water upon the carriageway notwithstanding that an inspection undertaken only four days previously on 17 May 2021 had not identified those defects. They had not been included in cleansing works undertaken on 8 April 2022.

(2) The evidence suggested that at around the point at which Mr Simms lost control of his motor car there were two separate patches of standing water upon the carriageway. They were said to be 62m in length and 36m in length respectively. They occupied the majority of the width of the Eastbound carriageway. Water was noted to a depth of between 10 and 15mm. There was plainly a significant quantity of standing water which posed a serious hazard to road users.

(3) Whilst the evidence I received did not establish on balance of probabilities that those blocked gullies were the cause of the patches of water described above, no alternative explanation for such a significant accumulation of water was provided by the evidence. It had plainly rained heavily, although there was no evidence to suggest an exceptional downpour had occurred.

(4) The absence of any explanation for this accumulation, and the consequential absence of any remedial action undertaken to prevent a repetition of these events gives rise to a concern that the highway at that location remains at risk of water ingress (from whatever source) unless and until the cause can be established and appropriate remedial action taken.

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 12th December 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] [Horwich Cohen Coghlan] – Representing the family of the deceased
- [redacted] [Keoghs Solicitors] – Representing [redacted] Suttons Transport Ltd

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 **17th October 2022** **SIGNED:**