REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Service Director for Transport, Cornwall Council** **2. [redacted] Project Manager for Safety, Cormac**
1	**CORONER** I am Guy Davies, Her Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.
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 Monday 18th March 2019 I commenced an investigation into the death of Ryan Gareth TAYLOR. The investigation concluded at the end of the inquest on 6th May 2021. The conclusion of the inquest was as follows Medical cause of death *1(a): Multiple Injuries.* *1(b): Road Traffic Collision* The four questions - who, when, where and how – were answered as follows … *Ryan Gareth TAYLOR died on 16th March 2019 at A390, Coliza Hill, St Austell, Cornwall from trauma sustained in a road traffic collision after he lost control of his vehicle due to aquaplaning in heavy rain.* Conclusion *Road Traffic Collision*
4	**CIRCUMSTANCES OF THE DEATH** Ryan died when his Jaguar XF suddenly veered across the road and collided with another vehicle, a Mazda MX5, which was travelling in the other direction. Ryan was pronounced dead at the scene by attending Paramedics. The driver of the Mazda, [redacted] sustained life changing injuries. The collision occurred during the hours of daylight. Visibility was poor due to heavy rain and poor light conditions. The road surface was very wet. The sky was overcast with heavy cloud. The court heard the following evidence in connection with road drainage at the scene. Coliza Hill Slip Road There are gullies on the south-eastern side of the slip road. These were clear of debris at the time of inspection, but due to the steep hill, under conditions of exceptional rainfall, it is possible that a fast flow of water may overwhelm the existing gully grid capacity. A change of camber takes water falling on the lower end of the slip road onto

	the main carriageway, although this is always likely to be the minor flow. A recommendation has been made by Cormac to enhance the size of or provide additional gully grids for better capture of water above the changeover point, and to minimise surcharge at the lower end of the slip road. A390 Coliza Hill (eastbound description) The A390 drains to the north-western side of the road in accordance with standard super elevation of the carriageway for the left-hand bend, until a short distance above the entrance to the layby, when the changeover occurs and water begins to drain along the road and then to the south- eastern side. Gullies intended to capture this water before the changeover point were fleeced over with debris from adjacent trees at the time of site visit. It is not known if this was the case at the time of the collision. Drainage standards have altered since the design and construction of the original A390 improvement, since adopting higher inundation calculations due to anticipated climate change and other factors. Cormac & Cornwall Council are investigating the capacity of the underlying drainage system and outfalls with a view to increasing both the size and number of gullies to improve capture and system resilience. The Inquest findings of fact were as follows • There was no evidence of excessive speed or unsafe driving by Ryan at the time of the collision or in the period leading up to the collision. Indeed, there was evidence from other road users that Ryan was driving appropriately for the conditions. • There was meteorological evidence a large band of heavy rain passing over the location of the collision and that just prior to the collision rainfall of 20 - 30 mm was recorded. Eyewitnesses referred to the driving conditions as being poor due to the heavy rain and excessive water. • Examination of road drainage at this location revealed that during periods of heavy rainfall surface water from the adjoining road known as Coliza Hill is likely to converge with surface water on the A390 in the vicinity of where the Jaguar initially lost control. • Ryan was driving a rear wheel drive car. The evidence of the forensic collision investigator was that a rear wheel drive car is more likely to aquaplane in these circumstances than a front wheel drive car. • The manner in which Ryan's car crossed the carriageway was found to be consistent with a rear wheel drive car aquaplaning in wet conditions. The forensic collision investigator's evidence was that Ryan would have had little or no warning of this sudden loss of control. From these findings of fact driver error was ruled out. The cause of the collision was found to be the surface water from Coliza Hill converging with surface water on the A390 following heavy rain just prior to the collision. The inquest found that Ryan lost control of his car as he was traversing the converging surface water which had inundated the road at this point. This caused the rear tyres of his vehicle to lose traction with the road surface, either causing it to rotate and suffer a sudden and catastrophic loss of control such as that witnessed by other road users, or causing Ryan to over steer in an attempt to regain control, which would have resulted in the same consequences.

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) During periods of heavy rainfall surface water from the adjoining road known as Coliza Hill is likely to converge with surface water on the A390 in the vicinity of where Ryan initially lost control of his car. (2) A rear wheel drive car had been involved in an aquaplaning incident at the same location in similar conditions, four years before this collision. (3) Improvements to road drainage are feasible in this particular location but have not yet been implemented. These improvements may diminish the risks of vehicles aquaplaning due to converging surface water.
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 21st July 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], Ryan's mother. I have also sent it to [redacted] 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	**25th May 2021** **Guy Davies**