Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Coroner** **2 Apple UK LIMITED** **3 Google** **4 TomTom**
1	**CORONER** I am Sean CUMMINGS, Assistant Coroner for the coroner area of Milton Keynes
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 20 November 2023 I commenced an investigation into the death of Amal Mohamed AHMED aged 38. The investigation concluded at the end of the inquest on 16 July 2024. The conclusion of the inquest was that: Road traffic collision
4	**CIRCUMSTANCES OF THE DEATH** Ms Amal Mohamed Ahmed died on the A5 southbound Little Brickhill at or adjacent to the point where the A5 joins the "off" slip road. She appears to have been using a satnav directing her to Queensway, Bletchley. The exact satnav application is not known due to the physical damage occasioned to the phone during the collision. She entered the exit to the off slip road at the Little Brickhill junction and drove the wrong way down the slip road, ultimately colliding with a vehicle travelling at speed on the A5 head on. Ms Ahmed died at the scene. The driver of the other vehicle died later at the John Radcliffe Hospital. A passenger of one of the vehicles required critical care treatment and suffered life threatening and changing injuries.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) I have made observations regarding the slip road at this junction in my initial pre-Inquest Report To Prevent Future Deaths dated the 21st December 2023. National Highways undertook a number of immediate remedial measures to try to prevent drivers turning and travelling the wrong way down this slip road, including narrowing the "mouth" of the slip road to one lane, placement of very large temporary "No Entry" signs and placement of signs indicating "Do Not Use Satnav" at the site. CCTV monitoring of driver behaviour was commenced. Police activity and monitoring by National Highways

	showed that despite these measures, drivers were still turning early and attempting to drive the wrong way down the slip road. Further enquiries by the police and information volunteered by members of the public who made the same incorrect manoeuvre led to the finding that while the visual map display on commonly used satnav applications at this junction displayed the correct information, the verbal commands gave information likely to confuse and direct drivers down the wrong slip road into the path of oncoming traffic. This was observed to happen frequently.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 October 17, 2024. 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 **National Highways** **Milton Keynes Council** **DirectLine Group** [redacted] I have also sent it to [redacted] who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 23/08/2024** **Sean CUMMINGS** **Assistant Coroner for** **Milton Keynes**