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 Ilkley Town Council**
1	**CORONER** I am Angela BROCKLEHURST, HM Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area
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 23 July 2021 I commenced an investigation into the death of Kyle James GOATER aged 25. The investigation concluded at the end of the inquest on 19 September 2023. The conclusion of the inquest was that: Upon the 20th July 2021, Kyle James Goater was travelling along Moor Road away from Ilkley, when his motor vehicle in good working order, approached a rising crest in the road which reduced his visibility of the road ahead. The road continued into a dip where a parked vehicle stood in a layby adjacent to the carriageway, on the offside. Unbeknown to Mr Goater an RAC van was stationary within the lane travelled by him indicating to turn right into the layby. Upon reaching the crest of the road Mr Goater became aware of the stationary RAC van, and braked to avoid a collision, which could not be avoided. As a result a of the collision between Mr Goater's car and the RAC van, a third vehicle travelling in the opposite direction became involved in the collision. Following the collision Mr Goater remained initially unable to free himself from his car, having suffered chest injuries which impacted upon his ability to breathe freely. The Ambulance Service was called to attend the scene, and whilst awaiting the arrival of a resource allocated to the incident, Mr Goater suffered a Cardiac Arrest: CPR was initially administered by the Police personnel prior to the attendance of the Ambulance crew , and then continued by a Paramedic, which failed to revive Mr Goater; with his death being certified at 18:58 hours at the collision scene that day.
4	**CIRCUMSTANCES OF THE DEATH** Kyle is a 25yr old young man who resides alone in Keighley. On Tuesday the 20th of July, Kyle has been the driver of a MGZS Motor Vehicle travelling from Ilkley towards Menston. As he has crested the brow of a hill he has collided with two separate vehicles. Kyle's vehicle sustained substantial damage. Police Officers from Bradford Road's Policing have attended the report of this collision. Initially Kyle was talking and mobilising at the scene of the incident. Kyle then began to complain of chest pain. His breathing then became shallow and he went into arrest. CPR was commenced by officers on scene.

	CPR continued until paramedics arrived on scene, they then took over. The paramedics continued CPR, until life was pronounced extinct at 18:58hrs.
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) As the deceased was travelling in his motor vehicle approaching the brow of the hill on Moor Road controlled by a speed limit of 50mph, no sign was in place to provide a warning as to a layby situated at the bottom of a dip the road which was unforeseen by the deceased. At the bottom of the dip a vehicle was indicating to turn right into the layby, which the deceased travelling in the same traffic lane was not able to avoid, an inevitable collision occurred and as a result of such collision the deceased lost his life. Had the layby been situated elsewhere or signposted well in advance of the crest of the hill it is likely that sufficient warning to an oncoming vehicle would have been provided in time to enable awareness of an oncoming vehicle and a reduction in speed from 50 mph.
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 March 10, 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 [redacted] [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: 05/02/2024**  **Angela BROCKLEHURST** **HM Assistant Coroner for** **West Yorkshire Western Coroner Area**