REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Wessex Water Services Limited, Claverton Down Road, Bath** **2. Dorset Council, County Hall, Colliton Park, Dorchester**
1	**CORONER** I am Brendan Joseph Allen, Area Coroner, for the Coroner Area of Dorset
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 the 22nd December 2022, an investigation was commenced into the death of Natalie Christina Mountford, born on the 9th March 1977. The investigation concluded at the end of the Inquest on the 5th February 2024. The Medical Cause of Death was: 1a Multiple Injuries Consistent with a Road Traffic Collision 1b 1c 2 The conclusion of the Inquest recorded that Natalie Christina Mountford died as a consequence of a Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** Shortly after midnight on 18th December 2022, Natalie Chistina Mountford was travelling from Shaftesbury to Sturminster Newton on the B3019 in her Vauxhall Astra, when she came across a single vehicle road traffic collision in the St

	James' Common area: a Vauxhall Corsa, driven by [redacted], had lost control on ice that was present on the B3091 and collided with one or both verges, coming to rest in the opposing lane, with the front of the vehicle pointing into the verge. Ms Mountford came to [redacted] assistance, and invited her to sit in the rear of her Astra to keep warm while they awaited the Emergency Services. Ms Mountford remained outside of the vehicle. Shortly thereafter, [redacted], driving a Citreon Berlingo, again travelling from Shaftesbury in the direction of Sturminster Newton, tried to stop at the scene, but lost control of his vehicle on the ice that was present on the road. He elected to mount the verge to drive around the passenger side of Astra. As he died so, Ms Mountord walked around the front of her vehicle and she was struck by the Berlingo. Ms Mountford died at the scene as a consequence of the injuries she sustained. Witnesses describe water flowing down the hill, with ice having formed as a consequence of the sub-zero temperatures that prevailed that night.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: 1. During the inquest evidence was heard that: i. There have been multiple road traffic collisions on this section of road within the seven years prior to Ms Mountford's tragic death, including another fatality in December 2017 caused by the presence of ice on this section of the road. ii. When Dorset Council highways inspections take place, the Inspectors will not consider or potentially investigate the possible source(s) of water running or on or across a road. While it is accepted that there will often be occasions where the source of the water will be obvious (eg excessive rain fall), there may

be occasions where the water is emanating from a source where remedial action can be taken to prevent the continued flow of water on to the road.

iii. Wessex Water do not appear to have a system in place to log and progress reports of potential leaks made directly to Wessex Water staff: a member of Dorset Council staff sent an email to a member of Wessex Water staff subsequent to the events of 18th December 2022 to alert them to the presence of a possible leak from the water pipe running underneath the B3091, which was causing water to flow down and across the road, warning of the risk that the water may freeze with the forecast temperatures. In preparation for the Inquest, Wessex Water could not find the email send by Dorset Council or any responses. In addition, though action was subsequently taken on 17th January 2023 to repair a leak at this site, it was part of Wessex Water's routine leak inspection process, and not in response to the information received from Dorset Council.

2. I have concerns with regard to the following:

i. This section of the B3091 appears to be an accident "black spot", with previous collisions likely to have occurred as a consequence of the presence of ice on the road, combined with a steep incline and a bend in the road;

ii. The presence of flowing water in a road is not considered and/or investigated by Dorset Council Highways Officers when conducting a highway inspection, leading to a risk that remedial action to stem the flow may not be taken, further leading to the continued presence of flowing water on a road. The presence of water itself could cause or contribute to a road traffic collision, but if the water were to freeze in sub-zero temperatures, the risk of a collision increases further;

	iii. There would appear to be no process in place at Wessex Water to log and action reports made directly to staff of water leaks onto a highway, or if a process is in existence it would appear not to be robust. The risk is that such reports may be "lost", with the necessary work not undertaken, leaving water flowing from a leak on the highway, with the subsequent risk outlined above.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, by 8th April 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: (1) Meesons & Spurlings Solicitors, representing [redacted], Natalie Mountford's daughter; (2) [redacted], Natalie Mountford's father; (3) [redacted], the father of Natalie Mountford's children; (4) Horwich Farrelly Solicitors, representing [redacted] on behalf of Ageas Insurance. 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	**Dated** 12th February 2024	**Signed**  **Brendan J Allen**