

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 CORONER

I am Simon MILBURN, Area Coroner for the coroner area of Cambridgeshire and Peterborough

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 17 July 2023 I commenced an investigation into the death of Colin Neil Duncan MCCALLUM aged 62. The investigation concluded at the end of the inquest on 16 May 2024. The conclusion of the inquest was that:

Mr McCallum was driving his Ford Focus westbound along the A1307 dual carriageway at Hemingford in Cambridgeshire at around 1545hrs on 14.07.23. It was raining heavily at that time. Mr McCallum was driving in lane two of the carriageway when his vehicle struck a patch of water. He lost control of the vehicle which crossed the carriageway to the nearside before entering the grassed hard shoulder where it struck a stationary vehicle which had stopped to assist another driver. Mr McCallum's vehicle then continued into the adjacent treeline before coming to a sudden halt. Emergency Services were called to the scene. Sadly Mr McCallum had suffered severe traumatic injuries as a result of the collision and despite attempts at resuscitation his death was confirmed at 1715hrs.

4 CIRCUMSTANCES OF THE DEATH

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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 understand that responsibility for this stretch of road was passed to CCC by National



Highways in Feb 2024. During the Inquest I heard evidence from National Highways Head Of Planning & Development(statement of attached). During the period Mar 2022 to Jul 2023 the Police were aware of 5 separate incidents on the stretch of the A1307 identified in statement where there had been personal injury or death to individuals caused after vehicles had hit patches of water before leaving the carriageway.

I am concerned that unless the risk of flooding/standing water is reassessed and managed/monitored moving forward that there is a risk of future deaths occurring in circumstances similar to that of the current case.

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 July 16, 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

I have also sent it to

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: 21/05/2024

Simon MILBURN Area Coroner for

Cambridgeshire and Peterborough