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:** [redacted] **Lead Director Infrastructure** **Norfolk County Council** **Martineau Lane** **Norwich** **NR1 2DH**
1	**CORONER** I am Samantha GOWARD, Area Coroner for the coroner area of Norfolk
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 21 December 2023, I commenced an investigation into the death of Barry John HOWARD aged 75. The investigation concluded at the end of the inquest on 16 July 2024. **The medical cause of death was:** 1a) Drowning 1b) 1c) 2) **The conclusion of the inquest was:** Accident contributed to by lack of visible warning signs of flooding and road closure.
4	**CIRCUMSTANCES OF THE DEATH** On 13 December 2023, Barry Howard was travelling along Mill Lane towards Shotesham Ford, an unbridged Ford, after 10pm. He was not familiar with the road which had previously been closed at the request of police due to flooding. The temporary signs indicating that the road was closed and impassable were not visible and the signs warning of the Ford and the depth of water, were beyond the flooded section of road, and on the balance of probabilities were not visible to Mr Howard before he entered the water. After entering the water his car was swept away into the river and he was found deceased in his car, which was almost completely submerged, at the Unbridged Ford, Mill Lane, Shotesham, Norfolk on 14 December 2023.

The findings at Inquest were that:

i. Based on the evidence of the police and the fact that they found road closed signs on the side of the road and face down the morning after the collision, on the night of 13 December 2023, while Barry was travelling home after 10pm in the dark, on the balance of probabilities, there were no appropriate, visible signs or barriers, leading to the Ford at Shotesham, to tell him that the road was closed and impassable.

ii. Anyone unfamiliar with the road, or unaware of the flooding, would not therefore have known that the road was closed.

iii. There are no warning signs that the road is liable to flooding. I heard evidence that there are many Fords across the county, many of which may not significantly flood, but this Ford is prone to deep flooding. Without a sign warning that the Ford may also flood, it is unclear how anyone unfamiliar with that particular Ford would be aware of the level of risk.

iv. The road surface was completely submerged around 40m prior to the sign for a Ford. The sign for the Ford was beyond the area that was flooded so anyone unfamiliar with the road had no notice of the close proximity of the upcoming Ford before entering the area of flood water.

v. The road slopes in the direction towards the Ford, so initially when entering the water it would not have been deep. It is not clear at what point it became so deep it was impassable or if there was a sudden change in depth. There was evidence in from reports from the Parish Counsil to Norfolk County Council that the surface of the road was very slippery. It is not possible to say whether Barry would have been able to brake and reverse easily after he entered the water and approached the Ford.

vi. I did not accept evidence that there is a gauge depth clearly visible from both approaches when the road is heavily flooded. Based on the police report & photographs the day after the accident, the gauge showing the depth of the flooded area was some way from the unflooded area of road and the road did not have street lights, and the gauge was on a bend - which, on the balance of probabilities, means that it would not have been clearly visible to Barry as he drove towards the flood, especially at night, so he had no way of knowing how deep the water was until he was some way in to the water.

vii. NCC Highways Dept were aware of difficulties with the Ford and that the signs and barriers, indicating that the road was closed were often moved and therefore not visible. They were also aware that the hinged sign to the east was damaged and inoperable.

viii. In accordance with the Traffic Signs and Regulations and General Directions 2016, when it became apparent that the road closure requested by police in October 2023 would be long lasting, there should have been an appropriate review and more permanent measures put in place including permanent and less mobile road closure signs, sufficient early warnings and a diversion. This would have prevented the issue of Barry driving down a closed and impassable road with no warning signs.

ix. It was my finding therefore on the evidence, that on the night of 13 December 2023 there was a lack of visible warning signs, before entering the flood water, of the proximity of the upcoming Ford, the impassable flooding and road closure.

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. While the evidence I heard was that the Council consider that the current signage is adequate & has been inspected, there was a history of incidents reported to them, and sadly the very tragic death of Barry. That suggests that, while they consider it adequate, it was not sufficiently so to prevent those incidents & Barry's death. I have heard nothing to reassure me that appropriate action has been taken to prevent others continuing to fail to be aware of the risk of the unbridged Ford, especially after heavy periods of rain. ii. A lack of any appropriate warning signs that this Ford is prone to flooding which may make it unsafe to cross. iii. A lack of signs sufficiently in advance of the Ford so as to warn road users at times of extreme flooding. The current signs were well within the flooded area on the night in question and I am concerned they would not be visible, especially to those unfamiliar with the road and in the dark, until they were already in the flood water. iv. The slippery surface of the road. v. The insufficiency of the temporary road closed signs used and the lack of more permanent measures, in accordance with guidelines, once the closure lasted more than 24 hours. It was only a week prior to the inquest, some 7 months after this death, that action was taken. I am concerned that such lengthy delays to implement safety measures will lead to a risk in future incidents at this and possibly other locations. vi. The evidence was that more appropriate measures for road closure should have been considered, but there was no evidence as to why they were not, or that this has been considered and action taken to address the reasons. I have not heard of any change to the way the team works, and I was repeatedly told they are a small team with a large area to cover – which means that there are risks of future issues with regards to the suitability of temporary signs and the correct procedures being followed when they need to be more permanent.
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 September 11, 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] I have also sent it to: Shotesham Parish Council RoSPA Department of Transport 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: 17/07/2024**  **Samantha GOWARD** **Area Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH