

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:

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1 CORONER

I am Sabyta KAUSHAL, Assistant Coroner for the coroner area of Derby and Derbyshire

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 March 2023 I commenced an investigation into the death of Matthew SCOTT aged 24. The investigation concluded at the end of the inquest on 22 April 2024. The conclusion of the inquest was that:

Matthew James Scott died on 11th March 2023 whilst travelling east on Station Road, Melbourne. The road had a speed limit of 40mph. He was travelling to his place of work at East Midlands airport when he hit a lengthy defective and subsided stretch of road which was filled with ice. That combined with his speed, which was likely to be in excess of 40mph, caused him to lose control, impact with a tree and sadly resulted in his death.

4 **CIRCUMSTANCES OF THE DEATH**

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)

At 6 weeks post Mr Scott's death - on the 28th of April 2023 - a discussion took place between collision investigator officers, a traffic management officer (all of Derbyshire police) with the Project Engineer of the Highways Authority of Derbyshire County Council. The officers raised their concerns that at the place where Mr Scott lost control of his vehicle (Station Road, Melbourne Derbyshire) there was a lengthy, defective and subsided stretch of road. Further that at the time of Mr Scott's death the subsided section of road was some 4 metres in width, 37 metres in length and 5 cms in depth. Further, that it was deep enough to have had standing water in it which at the time of Mr Scott's death had turned to ice.

Ice in the said defect would likely cause a vehicle to lose grip on the road surface. At that section of road, the road starts to bend to the right such that losing control on the ice could cause a vehicle to veer to the offside of the road, either into the path of an oncoming vehicle, into the opposite field or as in Mr Scott's case, a tree.

The Project Engineer of the Highways Authority discussed his concerns and the concerns



that had been raised by the police, with the highway maintenance department in early May 2023. As at the date of the inquest into Mr Scott' death (22 April 2024) this stretch of road had not been surveyed, no consideration had been given to the concerns of the police and no decisions taken to repair the defect so as to prevent any further accidents.

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 02, 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

PROJECT ENGINEER HIGHWAYS AUTHORITY

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: 07/05/2024

Sabyta KAUSHAL Assistant Coroner for Derby and Derbyshire