John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Cheshire Constabulary Clemonds Hey, Oakmere Road, Winsford CW7 2UA
1	**CORONER** I am John Adrian Gittins, Senior Coroner for North Wales (East and Central)
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 28th of February 2022 I commenced investigations into the deaths of Carl Anthony Butler (DOB 19.10.67 DOD 26.02,22) and Sean Brett (DOB 03.01.72 DOD 26.02.22) . The investigations concluded at the end of the inquest on the 17th of January 2025. In relation to both deaths, I returned narrative conclusions as follows: For Mr Butler – On the 26th of February 2022 whilst intoxicated, the deceased drove his vehicle in the wrong direction along the A55 at Broughton and into collision with an oncoming vehicle, sustaining unsurvivable injuries, and as a result he was verified dead at the scene. For Mr Brett - On the 26th of February 2022 on the A55 at Broughton, the deceased was the driver of a motor vehicle which was struck by another vehicle which was being driven in the wrong direction on the carriageway by a person who was over the prescribed drink driving limit. As a result of the collision Sean Brett sustained injuries which were incompatible with life and was declared deceased at the scene.
4	**CIRCUMSTANCES OF THE DEATH** On the 12th of February 2022, Carl Butler had been arrested, charged and bailed by Cheshire Constabulary in relation to a drink-drive offence. At approximately 05.15 on the 26th of February 2022, Cheshire Constabulary received report of an intoxicated driver leaving a petrol station in Chester. (This was Mr Carl Butler driving a vehicle registered to him). A report was put out requesting observations for this vehicle but the car and driver were not located. At approximately 11.45 the same day, Cheshire Constabulary received a further report in relation to this vehicle and to the erratic manner in which it was being driven. Around 30 mins later, Mr Butler drove his car the wrong way along the A55 dual carriageway, colliding with Mr Brett's' vehicle coming in the opposite direction, resulting in both their deaths. Subsequent tests established that Mr Butler was more than four and a half times the prescribed drink drive limit at the time of the collision.

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed the following matter giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows. – 1. There was a confused picture of the management of the reports and information being handled by Cheshire Police insofar as a request for observations would be put out to officers by a communications operator, however there was no requirement for any officer to acknowledge that they had received such a request and therefore no means by which it could be confirmed that any actions were being undertaken as a result of the reports which had been received. 2. There was also confusion within the control room as to the methodology by which a vehicle could be added to an ANPR/Vehicle Finder System, and although an IOPC investigation was finalised in February 2023 which identified potential learning for the force in respect of ensuring control room staff understand the appropriate processes, evidence was heard at the inquest that a witness had not received this training until December 2024 due to a lack of time being made available to her to undertake the same. (Where learning identifies required training/actions, any delays in delivering this, can only serve to perpetuate the risks which such training/actions is aimed at mitigating.)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 18th of March 2025 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 Families of the Deceased and to the Chief Coroner. 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 21st January 2025  Signature, Senior Coroner for North Wales (East and Central)