	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Secretary of State for Transport, The Department of Transport, 33 Horseferry Road, London SW1P 4DR.**
1	**CORONER** I am Mr Robert Chapman Assistant Coroner for **County of Cumbria**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 02/08/2017 I commenced an investigation into the deaths of Caitlin Lydia Huddleston and Skye Olivia Mitchell. The investigations concluded at the end of the inquests on the 21st September 2018. The essence of the two conclusions given at the end of the two inquests was that on the 14 July 2017 Caitlin Huddleston was the front seat passenger in a car being driven by Skye Mitchell on the A595 near Bootle Cumbria. The driver lost control on a bend on the wet road, moving across the road into the path of an oncoming van. Both Ms Huddleston and Ms Mitchell died at the scene from the injuries they received in the collision. Paramedics confirmed their deaths. The cause of death in both cases was 1.a. Multiple Injuries. The Conclusion in both cases was of "Death as a result of injuries sustained in a Road Traffic Collision"
4	**CIRCUMSTANCES OF THE DEATH** On the 14 July 2017 Caitlin Huddleston was with friends Skye Mitchell and [redacted], all of whom were 18 years of age, travelling in a Toyota Yaris motor car on the A595 northbound from Millom in Cumbria to a restaurant at Gosforth, Cumbria. Skye was driving the car which was owned by her father. Caitlin was the front seat passenger, and [redacted] was in the rear seat. The road was wet from rain and the vehicle has failed to negotiate a left hand bend. Skye has lost control moved initially to the left and then over-corrected and slewed sideways to the right, crossing the opposite carriageway and colliding with a white van being driven in the opposite direction, by Patrick Troll. The nearside of the Toyota was "t-boned" by the front of the white van causing significant intrusion into the passenger side of the Toyota. Caitlin was the front seat passenger and trapped in the vehicle. She was given CPR but was pronounced dead at the scene. Skye was taken from the drivers seat by members of the public who gave CPR in an attempt to resuscitate her however Skye was also pronounced dead at the scene. [redacted] was the rear seat passenger and was extracted from the vehicle suffering life changing injuries. The van driver, [redacted] also received life changing injuries. Caitlin, Skye and [redacted] were all wearing seat belts. [redacted] was not. Neither driver, nor passengers, had consumed any alcohol. Skye had passed her driving test on the 15 March 2017, just 4 months before the collision, and was described by her mother as being a nervous driver who panicked some times. The evidence from the police collision investigator was that it was likely that the loss of control on the bend was as a result of the bend being taken too quickly in the wet conditions, which may have arisen from her lack of experience as a new driver.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters 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 **MATTERS OF CONCERN** are as follows: – (1) That Skye was a driver with only 4 months driving experience after passing her driving test; (2) That she was accompanied by 2 friends of similar age in the car; (3) The circumstances of the loss of control are likely to be a direct result of the inexperience of the driver; (4) Whilst we do not know this is the case it is likely that Skye Catlin and [redacted] would be having discussions in the car at the time, and these may have distracted Skye when driving; (5) The carrying of passengers in the car increases the likelihood of death or injury not only to the driver but also to the passengers being carried, therefore multiplies the risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, The Department of Transport, have the power to take such action. The action that I have in mind is that consideration should be given to establishing a "Graduated Driving Licence Scheme" that would: (1) Ensure that the driving test would emphasise the risks of driving with passengers in the car (2) Enable a new driver to build up their driving skills and experience (3) Provide restrictions on a new driver for a limited period of time, for example for 6 months, limiting the ability of a new driver to carry passengers who have no or limited driving experience, and only carrying passengers who had sufficient experience (such as parents, driving instructors, etc) I understand that Graduated Driving Licence Schemes (in various guises) are in place in some countries and that there has been an indication of substantial success in reducing deaths and injuries as a result. Whilst the following matters were not relevant to the circumstances of the road traffic collision involving Caitlin and Skye's deaths, the Graduated Driving Licence scheme may apply to new drivers to: (a) Limit their speed (b) Limit the time of day when they can drive (c) Limit or bar the consumption of alcohol (d) Limit or bar the use of telephones (e) Encourage the use of seatbelts (f) Consider the use of "black box" technology to monitor the use of vehicles by new drivers I understand such schemes are in force in: Northern Ireland Ontario, Canada Some States in the USA New Zealand Australia
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 23 November 2018. 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] (parents of Caitlin) [redacted] (parents of Skye) Butterworths, Solicitors, who represent [redacted] DAC Law, Solicitors, who represent [redacted] the van driver

	Clyde & Co, Solicitors, who represent NFU Mutual, the Insurers of [redacted] Admiral Insurance Company, the insurers of Skye Mitchell The Cumbria Constabulary I have also sent it to the following persons who may find it useful or of interest: [redacted] Member of Parliament for Darlington [redacted] [redacted] Member of Parliament for Copeland [redacted] 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	25/09/2018 Robert Chapman Mr Robert Chapman Assistant Coroner **County of Cumbria**