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 [redacted] – Chief Executive Officer, Hampshire County Council** **2 [redacted] – Chief Executive Officer, National Highways**
1	**CORONER** I am Rosamund RHODES-KEMP, HM Area Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 09 July 2024 I commenced an investigation into the death of James Alexander SCOTT aged 25. The investigation concluded at the end of the inquest on 17 July 2025. The conclusion of the inquest was that: On the evening of 5th July 2024 James Scott, aged 25, was driving Southbound on the A33 when he lost control of the vehicle which turned sideways crossing onto the opposite carriageway colliding with a Northbound vehicle. He sustained fatal injuries and was sadly pronounced deceased at the scene.
4	**CIRCUMSTANCES OF THE DEATH** This report concerns a fatal road traffic collision between a Vauxhall Corsa and a Ford Ranger towing a SBS trailer upon which was a trailer, which occurred around 21:44 on Friday 5th July 2024 on the A33 near Kings Worthy, Hampshire. Mr Scott was travelling South in his Vauxhall Corsa where the vehicle has passed through an area of standing water. Consequently, the Corsa has entered a state of clockwise yaw, passing through the central reserve and into the path of the oncoming Ford Ranger which was travelling North. The Vauxhall and Ford have collided in 'T-Bone' formation, with Mr Scott sustaining fatal injuries and being sadly declared deceased at the scene. On examination it was observed that two of the drains to the nearside of the southbound lane were compacted with vegetation, resulting in little or no surface drainage. This is despite annual scheduled maintenance for year 2023/2024 taking place on 19th May 2023 and 15th November 2023. This included clearing gullies and catch pits either side of the A33. A Temporary "Flood" warning sign was located within the nearside grass verge, around 8 meters north of the commencement of the flooding. The 'Temporary' warning sign had been present for about 5 years prior to the collision. Whilst ownership of the sign is subject to debate between National Highways and Hampshire County Council, the area is known to be a flood risk and has been one for several years prior to the collision. The Forensic examiner concluded that the standing water was a contributory factor in the collision and was relevant to factors affecting Mr Scott.
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) During the course of the inquest the evidence 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] (1) The area is a known flood risk (2) Whilst the precise cause of the flooding is unknown, a more regular maintenance schedule may have prevented the buildup of vegetation within the gullies and therefore assisted in the drainage of the heavy rainfall experienced that day thus reducing the amount of surface water present on the road (3) The fact that only a Temporary Sign was in place in an area known for years to be a flood risk (4) The surface water was a contributory factor in this death
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 18, 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 Chief Coroner and to the following Interested Persons [redacted] I have also sent it to [redacted] 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: 24/07/2025**  **Rosamund RHODES-KEMP** **HM Area Coroner for** **Hampshire, Portsmouth and Southampton**