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 Lincolnshire County Council Legal Services** **2 National Highways (Midlands Region)** **3 Lincolnshire Police**
1	**CORONER** I am Jayne WILKES, H M Area Coroner for the Coroner area of Greater Lincolnshire
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 03 January 2025 I commenced an investigation into the death of Ayan SEDIQI aged 7 Months. The investigation concluded at the end of the inquest on 19 December 2025. The conclusion of the inquest was Road Traffic Collision. The medical cause of death was Traumatic Brain Injury.
4	**CIRCUMSTANCES OF THE DEATH** Ayan Sediqi died on 3 January 2025 at the Queens Medical Centre in Nottingham as a result of injuries sustained in a single vehicle road traffic collision on the A1, south of Grantham, Lincolnshire. He was a rear seat passenger in his parents' motor car and at 22:50 on 2 January the family were travelling back to their home. At the location of the collision, there was a significant volume of water flowing across both lanes of the southbound carriageway. With temperatures below freezing, some of this water had turned to ice. Following an uneventful overtaking manoeuvre, they encountered this ice as their vehicle returned to the inside lane of the A1. Their vehicle slid across the road and into a layby and then crashed into a tree before coming to rest back on the inside lane of the carriageway. The collision caused extensive damage to the vehicle, and fatal injuries to Master Sediqi. The source of the water was later identified as coming from a drainage pipe running adjacent to the A1 carriageway, which was blocked by the ingress of tree roots. Work has since been completed by National Highways to repair this drain. The A1 is a major road running North/South through part of Lincolnshire and is an extremely busy and well-used route.
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)

	Following a media appeal by Lincolnshire Police, responses were received from a large number of members of the public, who had been driving on the Southbound A1 on that day or earlier that week. From their accounts, and from dashcam footage provided, water had been flowing across the southbound carriageway at the collision site, from at least the early afternoon of 2 January, with some reports of it being noticed even earlier that week. These accounts included reference to concerns felt at the time that this was dangerous, particularly given the forecasted low temperatures for later that night. Other accounts from that evening describe how they had skidded on ice at this location, or that they had witnessed other vehicles skidding on the ice at the same spot. Officers who attended the scene immediately following the collision describe a large section of water flowing from the nearside verge across both lanes of the A1 southbound carriageway. Due to the drop in temperature, the road at this point was extremely icy, with a thick, white icy crust on the surface of the road. The road did not appear to have been gritted and was described as presenting dangerous conditions for members of the public driving that stretch of road. The weather at the time was dry and there had been no rain that day. Responsibility for road repairs and drainage of Lincolnshire's roads is shared between Lincolnshire County Council and the Highways Agency and is dependent on the particular road and location. Maintenance and repair of drains at the A1 at this point is the responsibility of National Highways. Both National Highways (Midlands Region) and Lincolnshire County Council described their websites during the inquest. Both include an online reporting process for concerns and faults encountered on the roads. Lincolnshire County Council also have a general telephone number for their Customer Service Centre (office hours) and outside this time, if the fault represents an immediate danger, their online guidance recommends contacting the police on 101. The National Highways website refers to reporting any emergency via 999, and that any other incidents relating to maintenance issues can be reported to their Customer Contact Centre on the number provided. This operates on a 24/7 basis. The Highways Agency also advised that they also do have available signage which displays their telephone number, but that this is usually only deployed, on a temporary basis, at sites of major pre-planned roadworks. Under the heading 'Report a Road Traffic Incident' the Lincolnshire Police website advises that in an emergency situation (this includes incidents where there is an 'immediate danger to life'), the user should call 999. Their online system for reporting road traffic incidents to the police refers to reporting collisions and driving offences only. As part of my investigation, the National Highways (Midlands Region), Lincolnshire County Council and Lincolnshire Police all checked their reporting systems, and confirmed they had not received any reports about flowing water or ice on this stretch of the A1 on 2 January 2025, and for the period of two months prior to this accident. Given the duration and extent of the flowing water / ice on the A1 at the location of this collision, and the number of road users who would have passed over it, it is my view that there is a lack of public awareness as to who, where and how motorists should report circumstances which present a risk of immediate danger to road users.
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 March 06, 2026. 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 family of Master Sediqi.

	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. She may send a copy of this report to any person who she 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: 09/01/2026** [redacted] **Jayne WILKES** **H M Area Coroner for** **Greater Lincolnshire**