<u>Inquest into the death of Michael Arthur Warren</u>

Held at Windsor Guildhall between 8th and 10th July 2014

Narrative Verdict

Michael Arthur Warren died on 5th October 2012 at Wexham Park Hospital, Slough from a head injury suffered when the car he was driving on the A332 Windsor Road, was accidentally struck by a large overhanging branch of a mature oak tree, situated on the nearside of the Windsor bound carriageway, that fell on to the road without warning.

The owner of the land on which the oak tree stood lived abroad and had not recently actively managed the land either himself or through agents. He was not aware of any action needed in respect of the oak tree involved and had not previously instigated any form of professional review of the trees on his land.

The Local Highways Authority operated a method of examination by Highway Inspectors of trees abutting the highway that included:

- a. a survey and inspection in 2008 by a tree expert;
- b. drive-by inspections on a monthly basis by Highway Inspectors, the last of which was two days before Mr Warren's death; and
- c. annual inspections by Highway Inspectors conducted on foot, the last one being in January 2012.

All these inspections included the relevant oak tree and no problems were identified.

Drive-by inspections involved Highway Inspectors being driven at speeds in the region of thirty miles per hour and recording any potential dangers to road users from obvious signs of decay to trees; potholes in the road; obscured signage etc. Concerns about trees were then reported to a Tree Officer for further specialist inspection.

Highway Inspectors received limited training in how to recognise tree problems. They relied on identifying obvious signs of decay such as lack of foliage and dangerous leaning or fallen tree sections.

Immediately following the incident on 5th October 2012, inspection of the now damaged oak tree revealed:

- a. advanced internal decay that would not have been obvious during a routine visual inspection;
- a large historic occluded wound near the base of the branch that fell that would have been potentially obvious even from a drive-by inspection;
- c. a large and severely unbalanced tree branch positioned above the carriageway of a busy road; and

d. trees surrounding the relevant oak in the same woodland strip that required pruning/felling because of their poor condition and which had not been identified by previous highway inspections.

The combination of visual signs was sufficient to have caused the landowner, his agent or a Highway Inspector to request a more detailed inspection of the oak tree by qualified Tree Officers.

Such an inspection, on the balance of probabilities, would have identified the unbalanced nature of the branch and the large occluded wound which, in turn, would have led to more detailed examination.

This, in turn, would have resulted in intervention works to the oak tree significantly reducing the risk of the branch falling as it did on 5th October 2012.

Signed	l	 	
•	Peter		

Senior Coroner for Berkshire

Dated this 10th day of July 2014

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used after an inquest.

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

- 1. Bracknell Forest Borough Council
- 2. Chartered Institution of Highways and Transportation
- 3.

1 CORONER

I am Peter J. Bedford, Senior Coroner, for the coroner area of Berkshire.

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 9th October 2012 I commenced an investigation into the death of Michael Arthur Warren. The investigation concluded at the end of the inquest on 10th July 2014. The conclusion of the inquest was a narrative as attached.

4 CIRCUMSTANCES OF THE DEATH

Michael Arthur Warren died from serious head injuries suffered when the car he was driving was struck on its roof by the large branch of a mature oak tree that unexpectedly fell without warning as he drove beneath it on 5th October 2012.

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) The evidence at the Inquest revealed that Bracknell Forest Borough Council employ Highways Inspectors to carry out driven and walked inspections in order to attempt to identify any potential hazards that might impact adversely on road users.
- (2) The Highway Inspectors were expected to identify a range of potential problems including potholes in the road, damaged or obscured signage and potential hazards from trees abutting the highway which were often of considerable height. There was little by way of guidance given to Highways Inspectors who had developed their own system of drive-by investigations conducted at a speed rarely less than thirty miles per hour.
- (3) The evidence highlighted the limited nature of training provided to Highway Inspectors in identifying potential hazards from trees. The two Inspectors who conducted a drive-by survey two days before the branch fell and killed Mr Warren and who had noted nothing of concern, had not completed any form of tree training since a two day course some seven years earlier. Another Highway Inspector who gave evidence at the Inquest, had never attended a formal training course with regard to tree hazards.
- (4) There is therefore a need for appropriate guidelines to be provided by Bracknell

Forest Council to Highway Inspectors to ensure that they are properly trained in tree issues; that they have an appropriate system of work that ensures that they drive at a speed appropriate to maximise the chances of identifying tree hazards and that there should be a series of inspections which are limited to only the inspection of trees.

(5) The evidence also revealed that there was very little by way of clear, detailed guidance available to Local Authorities as regards the appropriate systems of highway inspection of trees abutting the highway. There is a potential need for clear direction from a suitably qualified source to assist Local Authorities in this crucial role.

(6) The owner of the land on which the relevant oak tree stood lived abroad and had no arrangements for professional review of the trees on his property, in particular those that were close to the highway and therefore a potential hazard to road users. It was of concern that the lack of active management of the owner's land continued some two and a half years after Mr Warren's 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 Friday 12th September 2014. 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 - Bracknell Forest Borough Council, The Chartered Institution of Highways and Transportation and Mr

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 **17th July 2014**

Senior Coroner for Berkshire