	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Network Delivery and Development Yorkshire, North East Regional Director, Highways England, Lateral, 8 City Walk, Leeds LS11 9AT,** [redacted]
1	**CORONER** I am Crispin A Oliver assistant coroner, for the coroner area of County Durham and Darlington
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 7th April 2015 I commenced investigations into the death of Kenneth ("Ken") McCurdy and Mary ("Maida") Brunton Cunningham McCurdy. The investigations concluded at the end of the inquests, heard together, on 30th of September 2015. The conclusion of the inquest was that both Mr and Mrs McCurdy had died from 1a Multiple Traumatic Injuries. They died on the 1st of April 2015 at approximately 15.52 hours near the A66 at East Lowfield Farm, Bowes, County Durham following a road traffic collision and the conclusions were that of accidental deaths.
4	**CIRCUMSTANCES OF THE DEATH** Mr and Mrs McCurdy were travelling eastwards in their Seat motor car towards Barnard Castle approaching the exit to Hulands Quarry on the left hand side of the dual carriageway. Mr McCurdy was driving. For reasons that could not be explained he executed a manoeuvre that took him through the gap in the central reservation designated for traffic in the opposite direction carriageway to turn right across the east bound carriageway into Hulands Quarry. He collided almost instantaneously with a vehicle travelling westwards in the other carriageway. The driver of that vehicle had no chance to avoid the collision. That driver was probably driving lawfully, within the speed limit.
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. There is no signage at the gap in the central reservation for vehicles travelling west to turn right towards Hulands Quarry to indicate that it is no entry to vehicles travelling east for any form of manoeuvre. 2. There is no signage at or leading up to the said gap in the central reservation to indicate that there is a prohibition to U turns or right turns to vehicles travelling east.
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 26th November 2015 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 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	**1 October 2015** **Crispin A Oliver M.A.**