	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 9th April 2015 I commenced an investigation into the death of Charles Ernest Rayner, born 10th July 1952. The investigation concluded at the end of the inquest on 30th of September 2015. The conclusion of the inquest was that Mr Rayner died of multiple traumatic injuries resulting from a road crash traffic collision on the A66 trunk road in County Durham, West of Bowes near the Otter Trust turnoff on the 6th of April 2015. At about 10.00 a.m. He was overtaking vehicles on his motorcycle when he collided with a vehicle and trailer turning right at the intersection where there was no right turn slipway. The conclusion was that of accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Rayner was travelling on his motor cycle in a westerly direction on a duel carriageway section of the A66 past Bowes and heading towards the Otters Trust turnoff. At the time of the collision he was probably travelling at 86 miles per hour in a 70 miles per hour limit while overtaking in the outside lane. The motor cycle was in proper working order and he was properly equipped and in all other respects acting lawfully. He may have had difficulty in seeing the brake and indicator warning lights on the vehicle and trailer he collided with as a result of the combination of sunlight reflecting off them and the effect of his motorcycle sun visor, but it was reasonable for him to have been using this. The vehicle and trailer he collided with were also travelling in a westerly direction on the A66 when the driver manoeuvred to turn right into the central reservation intending to enter the moors via a small access road, this entrance being off the eastbound carriageway opposite the Otters Trust turnoff. The driver of the vehicle and trailer was manoeuvring lawfully but it was necessary for him to reduce his speed to near standstill for the manoeuvre to be completed. This was done in the outside lane because there is no slip road/deceleration lane. Mr Rayner, travelling in the outside lane, was unable to take avoiding action because of vehicles in the inside lane. The collision ensued resulting in his death.
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 crossover point between the Otter Trust and access road to the moors, traveling West, does not have a slip road/deceleration lane for traffic travelling west such that to

	carry out the turn it is necessary to reduce speed to a virtual standstill in the outside lane. 2) There is no prohibition on a right turn by way of appropriate signage.
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** C A Oliver. **Crispin A Oliver M.A.**