REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Highways Department, Durham County Council, County Hall, Durham DH1 5 UL

1 CORONER

I am Andrew Tweddle, Senior 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 30th June 2016 I commenced an investigation into the death of Warren Michael Myers aged 49 years. The investigation concluded at the end of the inquest on 8th February 2017. The cause of death was

1a. Traumatic Chest Injuries

The conclusion of the inquest was Road Traffic Collision

4 CIRCUMSTANCES OF THE DEATH

The deceased died in a fatal road traffic collision which occurred at around 19:50 hours on Wednesday 22nd June 2016 on the unclassified 42.3 Brusselton Lane road between the A698 road and the A6072 road, County Durham. Road and weather conditions were good. The deceased was riding a motorised trike which was found to be in a road worthy condition. The deceased failed to negotiate a right hand bend and evidence indicated that he was driving too fast for that bend, though well within the speed limit of 60 miles per hour. There was no evidence to indicate that he had been driving inappropriately prior to the collision. The evidence was that he was driving along a road with which he was not familiar and was caught out by the severity of the right hand bend. The Police report notes that the kerb on the corner was peppered with marks indicative of it having been struck on a number of previous occasions. The Police indicated that they had been called to other incidents on this corner before and it was known to them. There are some warning signs. Evidence was given that the local authority had considered whether the load signage was adequate and deemed appropriate. The senior investigating officer believed that the signage was not adequate and that more needed to be done to warn road users of the severity of this bend. Evidence was given that a safe speed to go around the corner in a car would have been in the region of 25-30 miles per hour. It was suggested in evidence that warning signs could be affixed to them of an advisory (and unenforceable) maximum speed limit direction which would give motorists a better appreciation of the hazard that they were approaching.

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 warning signage on the approach to the corner is inadequate.

6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you 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 5 April 2017. 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.
	I have also sent it to who may find it useful or of interest.
	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	Signed. Signed.
	HM Senior Coroner County Durham and Darlington
	Dated. 9-12-1