	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Traffic Section, Durham County Council, County Hall, Durham**
1	**CORONER** I am JAMES E THOMPSON, 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 September 2017 I commenced an investigation into the death of Shaun David Neal, 46 years. The investigation concluded at the end of the inquest on 15th April 2019. The conclusion of the Inquest was Shaun David Neal died as a result of a road traffic collision whilst riding his motorcycle on A68 near Tow Law, Co. Durham on 2nd September 2017. He collided with an on-coming motor vehicle and as a result suffered fatal injuries and died at the scene of the collision.
4	**CIRCUMSTANCES OF THE DEATH** Mr Neal was killed when a vehicle in the opposing lane overtook a vehicle and in doing so struck Mr Neal and caused him a fatal injury
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. Evidence heard at inquest confirms only 'broken' white line hazard road markings were present on the road surface at the location of the collision 2. Durham County Council Traffic Section have surveyed the scene and found no requirement to change the road markings from broken hazard white lines to double solid white lines as it was thought a short section of double white lines may confuse drivers. 3. Expert evidence from a police collision investigator believed the presence of double white solid line markings would, in a driver obeying the restriction prevent such a manoeuvre that led to the collision, by removing the option to overtake on that section of road.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, 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 10th June 2019. 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 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**..... **Dated**...15th April 2019