

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>1. Highways Agency</b> <b>2. Hartlepool Borough Council</b></p>
1	<p><b>CORONER</b></p> <p>I am C.W.M.Donnelly, senior coroner for the coroner area of Hartlepool, &amp; assistant coroner for the area of Teesside</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 14<sup>th</sup> June 2014 I commenced an investigation into the death of Keri Victoria Holdsworth. The investigation concluded at the end of the inquest on 16<sup>th</sup> February 2015. The conclusion of the inquest was accidental death, following a road traffic crash on the 13<sup>th</sup> June 2014 wherein the deceased sustained fatal injuries.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>On the 13<sup>th</sup> June 2014 the deceased was involved in a road traffic crash at the junction of the A19 road and the road from Dalton Piercy village. She had been travelling northwards in the offside lane, and probably braked suddenly as a van in the central reservation was about to pull out and join the northbound carriageway. She lost control of her vehicle, crossed over the junction and collided almost head on with a southbound vehicle travelling in the offside southbound lane.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>(1) This is the latest in several serious incidents at this junction, three of which have been fatal within the last five years. All of the fatal incidents have involved vehicles either turning right at this junction to join the northbound A19, or turning right from the northbound into the Dalton Piercy junction.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>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. The specific action is the closure of the junction to traffic wishing to turn right.</p>

7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 April 2015. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Person – [REDACTED] - who may find it useful or of interest.</p> <p>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.</p>
9	<p><b>18 February 2015</b></p> <p>[REDACTED]</p> <p>C W M Donnelly</p>