

Karen Dilks Senior Coroner for the City of Newcastle Upon Tyne

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	Director Of Transport Strategy
	Gateshead Council Civic Centre Regent Street Gateshead NE8 1HH
	CORONER
	I am Karen Dilks, Senior Coroner for the City of Newcastle Upon Tyne
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
3	On 17/12/2014 I commenced an investigation into the death of Paul Coxon, aged 40 years.
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	The investigation concluded at the end of the Inquest on 15th July 2015. The conclusion of the Inquest was ACCIDENTAL DEATH.
	Mr Coxon having suffered injuries when struck by a motor vehicle on the A1 at 9 Redheugh Bridge south bound slip road Gateshead on the 13 th December 2014. The cause of death was TRAUMATIC BRAIN INJURY.
	CIRCUMSTANCES OF THE DEATH
4	Paul Coxon was generally fit and well. On the evening of the 13 th December he consumed alcohol during a social evening. He walked onto the A189 Redheugh Bridge. Whilst on the south bound slip road off the A189 he crossed the carriageway directly into the path of an ancoming vehicle.
	The road layout is such the driver visibility of any potential hazard is limited. The speed limit is such that it is significantly impacts upon reaction time once a hazard becomes visible.
	A safe designated underpass crossing point is signposted but not illuminated. The incident on the 13 th December occurred during the hours of darkness.
	At the time of the incident Mr Coxon was under the influence of alcohol. As a result of the incident he sustained a traumatic brain injury that caused 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 i is my statutory duty to report to you.
	The MATTERS OF CONCERN are as follows
	[BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Inadequate signage giving guidance to pedestrians of safe crossing points (2) Lack of illuminated signage to assist pedestrians in the hours of darkness (3) Appropriateness of 50 mile per hour speed limit on a complex slip road where driver visibilit is limited and reaction time to any hazard significantly impaired as a result

6	ACTION SHOULD BE TAKEN
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	In my opinion action should be taken to prevent future deaths and I believe you Director Of Transport Strategy 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 14 th September 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 (the deceased parents) I have also sent it to PC AE Brown, Collision Investigator Northumbria Police 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	Dated 20 July 2015
	SignatureSenior Coroner for the City of Newcastle Upon Tyne