

Karen Dilks Senior Coroner for the City of Newcastle Upon Tyne

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
1	Head Of Technical Services County Hall Durham County Council Durham DH1 5UQ CORONER
1	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
	On the 13 th May 2015 I commenced an Investigation into the death of Steven Nicholson, DOB: 24 th March 1991, aged 24 years. The Investigation concluded at the end of the Inquest on the 24 th March 2016.
4	CIRCUMSTANCES OF THE DEATH
	Mr Nicholson was the driver of a motor vehicle on the A1018 entry slip road onto the A19 Southbound Seaham, and was continuing, visibility was poor. The A1018 has no street lighting, and an area of standing water approximately 68 meters long by meters wide, had formed on the A1018 beneath the B1404 over bridge. Mr Nicholson had no prior warning of the presence of the water, lack of street lighting and weather conditions hindered his visibility. His vehicle struck the water and he lost control. A collision ensued, in which Mr Nicholson sustained fatal head injuries. The Collision Investigation and Reconstruction concluded that the water pool on the A1018 was the principle cause of the Incident.
	There were no formal records of any previous incident of flooding on the A1018 within Durham County Council's reporting system.
	There was witness evidence including that of the deceased's family of a number of previous incidents of flooding at this location.
5	CORONER'S CONCERNS
	The MATTERS OF CONCERN are as follows. –
	[BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The absence of appropriate lighting on the A1018 slip road, to assist motorists in identifying and reacting to sudden unexpected hazards.
	(2) The absence of appropriate signage warning motorists of the risk of flooding on the A1018 slip road.

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 . 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 I have also sent it to Collision Investigator, 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 30 March 2016
	SignatureSenior Coroner for the City of Newcastle Upon Tyne