Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS	
THIS REPORT IS BE	1 Image: Corporate Director Regeneration and Local Services Durham County Council County Hall Durham DH1 5UL
1 CORONER	
I am Jeremy Chipp	perfield, Senior Coroner for the County Durham and Darlington coroner area.
2 CORONER'S LEG	GAL POWERS
	under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 oners (Investigations) Regulations 2013.
3 INVESTIGATION	N and INQUEST
	ary 2019 I commenced an investigation into the death of David Steward MOORE aged 45. concluded at the end of the inquest on 27 November 2019, The conclusion of the inquest
ACCIDENTAL DEAT	ТН
I a Head and Neck I b I c II	Injuries
4 CIRCUMSTANC	ES OF THE DEATH
around 565 metre	s on 28 January 2019, the deceased was crossing an area of unlit road on the A693, s west of the Beamish roundabout, when he was struck by a motor car being driven n the speed limit, with dipped headlights.
5 CORONER'S CO	INCERNS
	ONCERN is that the following circumstances together create the risk that other deaths wil mstances are that -
The section	on of the A693 where the collision occurred is:
• a	a de facto pedestrian crossing point connecting footpaths intersecting that road; an area to which the national speed limit applies (60mph for cars); very dark at night, being unaffected by ambient illumination; without street lighting

without street lighting

The material section of road is a natural crossing point for pedestrians travelling between two footpaths

leading between the collision site: and (i) the village of No Place, to the south of the A693 and (ii) the village of Kip Hill, to the north of the A693.

I accepted the following evidence about the material section of road (given by a police Collision Investigator): (i) the road is approximately 12m wide, and after nightfall is "in complete darkness", being bordered by dense trees and unaffected by discernible ambient light; (ii) drivers are entirely reliant on headlamp illumination to detect pedestrians; (iii) in reliance on his own dipped headlamps, a driver could gain first sight of a static pedestrian in the carriageway at a distance of no more than 40m from that pedestrian; and (iv) a motor car travelling at 60mph would require significantly more than 40m (around 80m) to come to a halt (taking into account driver reaction time and mechanical stopping distance).

In this case, the driver first saw the deceased "just prior to the collision" when the latter was running "with large strides" towards the southern side of the A693. Despite emergency breaking, he failed to avoid the collision. It was impossible to stop in the available distance.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and 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 24 January 2020. 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 who may find it useful or of interest: Chief Coroner of England and Wales, Strategic Traffic Manager, Strategic Traff

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.

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Jeremy CHIPPERFIELD Senior Coroner for County Durham and Darlington Dated: 03 December 2019