

NOTE: This form is to be used after

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PREVENT FUTURE DEATHS

an inquest.

1a) Subdural Bleed, Diffuse Axonal Injury and Brain Swelling

The deceased died at the Royal Victoria Infirmary in Newcastle on the 4th of July 2022 as a result of fatal head injuries sustained in a road traffic collision on the 2nd July 2022. The collision occurred when the deceased pulled out of a side road, Pittington Road, into the path of a vehicle travelling in the

1b) Road Traffic Accident Causing Severe Head Injury

REGULATION 28 REPORT TO PREVENT DEATHS THIS REPORT IS BEING SENT TO: (Chief Executive Officer) Durham County Council 1 **CORONER** I am Janine RICHARDS, 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. 3 **INVESTIGATION and INQUEST** On 12/07/2022 an investigation was commenced into the death of Kelly Nicola DUNNE. The investigation concluded at the end of the inquest on 20/02/2023. The conclusion of the inquest was one of Road Traffic Collision. The medical cause of death was:-

(Craniectomy on 02/07/2022)

outside lane of the A690.

CIRCUMSTANCES OF THE DEATH



5 CORONER'S CONCERNS

During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The MATTERS OF CONCERN are as follows:

During the course of the Inquest evidence was heard from the lead road traffic collision investigator in the case that there are significant concerns in relation to the adequacy and layout of this particular junction and the five other junctions on this stretch of road (A690). Evidence was given that since this fatality, there has been another fatal road traffic collision on the 22/12/22, at the junction directly opposite. Further that between 11/01/00 and 31/12/22 there have been 21 collisions at this junction (including this fatality and 3 other serious collisions) and that there have been 29 collisions at the other junctions on this stretch of road (including one further fatality and 6 other serious collisions).

The concerns in relation to this junction, and the other junctions relate to:-

- 1. The volume of traffic that the junctions must manage.
- 2. The complexity of traffic movement at the junctions.
- 3. The speed limit in the vicinity of the junctions.

Concerns were also raised in relation to the planned extensive expansion/development of the area in the vicinity of the junction, including increased housing development, a proposed retail park, football site, as well as developments occurring more widely in the area which will lead to increased traffic, and that any proposed improvements to the junction are not required until prior to the occupation of the 39th dwelling on the site. The concern is that the proposals to improve the safety of the junction are not sufficient nor timely, and that consideration does not appear to have been given to reducing the speed limit within the junction series. A further concern was raised that the proposed improvements to the junction considered this junction in isolation, and did not consider the series of junctions on this stretch of road.

ACTION SHOULD BE TAKEN

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.



	LOND TO NO
7	YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by May 08, 2023. 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 $\label{eq:coroner} % \begin{center} \end{corps and copy} \begin{center} \end{center} \begin{center} \e$

I have also sent it to

who

may find it useful or of interest.

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any person who I believe may find it useful or of interest.

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.

30/07/2021

Dated: 13/03/2023

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Janine RICHARDS Assistant Coroner for

County Durham and Darlington

Regulation 28 – After Inquest Document Template Updated