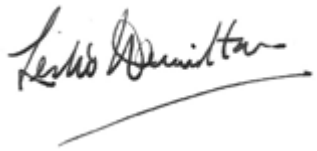
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1** [redacted]
1	**CORONER** I am JR Leslie HAMILTON, 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 23/08/2023 13:37an investigation was commenced into the death of Scott Andrew PUNSHON 16/06/1987 00:00:00. The investigation concluded at the end of the inquest on 30/05/2024 11:00. The conclusion of the inquest was that Scott Andrew Punshon was a 36 year old man who was found deceased, lying on the road (the A689 Road near Howden Le Wear) on the 12th August 2023. He was walking home from Crook in the early hours, having spent the evening with friends drinking. The collision investigation and the injuries identified at post mortem showed that he had been lying in the road when the car struck him. Toxicology showed a blood alcohol of 280mg/100mls and evidence that he had consumed cocaine and cannabis..
4	**CIRCUMSTANCES OF THE DEATH** Scott Andrew Punshon was a 36 year old man who was found deceased, lying on the road (the A689 Road near Howden Le Wear) on the 12th August 2023. He was walking home from Crook in the early hours, having spent the evening with friends drinking. The collision investigation and the injuries identified at post mortem showed that he had been lying in the road when the car struck him. Toxicology showed a blood alcohol of 280mg/100mls and evidence that he had consumed cocaine and cannabis.
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: (brief summary of matters of concern) On the 13th September 2023, on behalf of Durham County Council, you carried out a site investigation (Fatal Accident Report M/T/R11/23) which identified issues with road markings, signage and lighting. You made recommendations that these should be addressed by the DCC Technical Services personnel.
6	**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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by September 23, 2024. 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 [redacted] 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.
9	**Dated: 29/07/2024**  **JR Leslie HAMILTON** **Assistant Coroner for** **County Durham and Darlington**