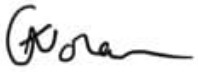
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Network Manager, Gateshead Council 2. [redacted], Strategy Director, Gateshead Council
1	**CORONER** I am Georgina Nolan, Senior Coroner for Newcastle and North Tyneside.
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 25th May 2023 I commenced an investigation into the death of John Michael Liddle, aged 44. The investigation concluded at the end of the inquest on 10th January 2025. The conclusion of the inquest was Road Traffic Collision. The medical cause of Mr Liddle's death was 1a) Blunt head injury.
4	**CIRCUMSTANCES OF THE DEATH** On the night of 3rd May 2023 John Michael Liddle was riding his pedal cycle southwards along the A694 Lockhaugh Road, Rowlands Gill, Gateshead. His cycle lights were illuminated and he was wearing a yellow cycling jacket. As he moved out towards the centre of the road to take the turn into Sherburn Park Drive he was hit by a minibus travelling behind him who was overtaking. Mr Liddle suffered unsurvivable head injuries and died at the Royal Victoria Infirmary Hospital in Newcastle upon Tyne on 21st May 2023.
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 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. – (1) At the time of the collision the area of the A694 upon which Mr Liddle was cycling was subject to a 40 miles per hour speed limit; (2) The speed limit on this area of road has now (temporarily) been reduced to 30 miles per hour; (3) The road is within a residential area; (4) The road encompasses bends and junctions; (5) There have been a number of other collisions along the stretch of road involving pedal cycles, pedestrians and motor vehicles; and (6) A 40 miles per hour speed limit is unsafe for this stretch of road.

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 7th March 2025. 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 interested persons, namely Mr Liddle's family and the driver of the minibus involved in the collision. 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. She may send a copy of this report to any person who she 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	**[DATE]** **[SIGNED BY CORONER]**  **9th January 2025**