KALLY CHEEMA

SENIOR CORONER

County of Cumbria

Fairfield

Station Rd

Cockermouth, CA13 9PT

[redacted]

[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. **National Highways (formerly Highways England) of Bridge House, 1 Walnut Tree Close, Guildford, GU1 4LZ.**

2. **Cumbria County Council of Cumbria House, 117 Botchergate, Carlisle, CA1 1RD**

CORONER

I am Craig Smith, Assistant Coroner for the coroner area of Cumbria.

CORONER'S LEGAL POWERS

I make this report pursuant to paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

INVESTIGATION AND INQUEST

On 19 November 2019 an investigation was commenced into the death of Stephen Cloudsdale (61 years). The investigation concluded at the end of the inquest on 27 January 2022. The conclusion of the inquest was that Mr Cloudsdale died as a result of a Road Traffic Collision; the medical cause of death being severe head injuries.

CIRCUMSTANCES OF THE DEATH

At approximately 5:30am on 11 November 2019, Stephen Cloudsdale had been travelling in the eastbound dual carriageway of the A66 at Stainmore in Cumbria. At the time, Mr Cloudsdale was travelling to his place of work in North Yorkshire, having set off from his home address in Millom. He was

familiar with the road and with the controls and handling of his vehicle (a Ford Fiesta) which he had owned for approximately two years.

At the time of the incident, it was dark, and it was raining heavily.
As Mr Cloudsdale approached the Stainmore Café, which is set back from the dual carriageway to the left, he moved into the second lane of the dual carriageway in order to initiate an overtake of a vehicle travelling in the first lane. He was utilising his car's dipped beams at this time, and it is estimated that he was travelling at a maximum speed of 75 mph.

As Mr Cloudsdale approached the area of the central reservation connecting the east and westbound dual carriageways, he collided with the rear offside corner of an LGV which was positioned in the central reservation waiting to turn right onto the westbound carriageway. The rear offside corner of the LGV encroached into lane 2 of the eastbound carriageway by approximately 1 metre.

Mr Cloudsdale sustained non-survivable traumatic head injuries as a result of the collision and death was diagnosed at the scene at 5:50am.

The LGV had been parked overnight in the carpark of the Stainmore Café and the driver had set out to enter the westbound lane to begin his working day. The café is frequently used by LGV drivers, and the central reservation will be used by the drivers of such vehicles upon exiting the carpark in order to enter the westbound carriageway. The café does not remain open 24 hours a day and the premises are unlit after the daily close of business.

The inquest heard from a police officer who had prepared a collision investigation report and who had carried out a reconstruction of the incident utilising the LGV and a Ford Fiesta to simulate the positions of the vehicles at the time of the collision. The reconstruction was conducted during the hours of darkness to replicate the visibility conditions as far as possible.

It was determined from the evidence heard that:

- there is no lighting on the stretch of dual carriageway where the collision occurred;
- the national speed limit (70mph) applies to this stretch of carriageway;
- there does not appear to be sufficient or any signage warning of the dangers of large vehicles crossing the eastbound dual carriageway;

- visibility would have been further hampered by the adverse weather conditions at the time of the collision;
- Mr Cloudsdale had been travelling at a maximum speed of 75mph at the time of the collision;
- the hazard lights/reflectors on the side of the LGV would have been visible to Mr Cloudsdale from a distance of 223.7 metres;
- at a distance of 223.7 metres, the hazard lights could easily be mistaken for lights in the opposing carriageway and that the outline of the LGV could not be seen at that distance when dipped beams were employed;
- the LGV would have become clearly visible to Mr Cloudsdale at 32.1 metres when dipped beams were employed;
- travelling at 75mph, Mr Cloudsdale would have had 0.96 seconds in which to take evasive action to avoid a collision;
- research suggests that most drivers will respond to a hazard in 1.5 to 2.0 seconds;
- the collision occurred when Mr Cloudsdale's vehicle struck the rear offside corner of the LGV which encroached into Mr Cloudsdale's lane by approximately 1 metre.

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 will 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) The lack of lighting near to or at the point of the A66 dual carriageway where the collision occurred which renders the presence of vehicles crossing the carriageway from the café difficult to see by approaching drivers during the hours of darkness and/or during adverse weather conditions.
2) The lack of appropriately positioned signage, warning approaching drivers of the possibility of vehicles crossing the carriageway from the café.
3) The speed of traffic on this stretch of the A66.
4) The sufficiency of the width of the central reservation to accommodate large vehicles fully without the danger of encroaching into either of the opposing carriageways.

ACTIONS SHOULD BE TAKEN

In my opinion, action should be taken to prevent future deaths and I believe you AND/OR your organisation has the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report. 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.

COPIES AND PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, Mr Cloudsdale's family, the insurers of the LGV driver, and the Chief Constable of Cumbria Constabulary.
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.

SIGNED BY THE CORONER

DATE – 3 February 2022