ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Chief Executive, Highways England Co. Ltd** 2. **Cumbria County Council (Highways)**
1	**CORONER** I am Simon Ward, assistant coroner, for the coroner area of Cumbria
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 24th May 2019 an investigation was commenced into the death of Daniel Bancroft (37years). The investigation concluded at the end of the inquest on 29th September 2020. The conclusion of the inquest was that he died as a result of a Road Traffic Collision; the medical cause of death being severe cervical and thoracic spine injuries.
4	**CIRCUMSTANCES OF THE DEATH** Mr Bancroft, an ex-serviceman, was happily married and a father of three. He had been for a night out socialising in Workington. He became extremely inebriated, and in the early hours of the morning decided to walk home to Cockermouth some 9 miles east of Workington. The evidence was that he had done this on a number of occasions. He decided to walk along the A66(Stainburn bypass) trunk road. He was struck by a motor vehicle being driven on the eastbound carriageway by an off duty special constable. He died of the resultant injuries. The inquest heard from a police officer that he himself had on previous occasions picked up three pedestrians on the stretch of road where the accident occurred in very similar circumstances. He described the road as a "fast road" and that the lack of lighting was "a massive factor", and it " needs lighting there definitely, it's so dark" The inquest had the benefit of collision investigator's report which stated amongst other things: 1 The accident occurred on the A66 just east of the roundabout adjacent to the Workington Academy. The eastbound carriageway has two lanes at this point with a speed limit of 60mph. The westbound has one lane. There is limited lighting from the roundabout to the national speed limit sign on the bypass. 2.Mr Bancroft was struck on the nearside of the eastbound lane at 03:36 3. The car was travelling at about 60mph (26.82m/s) 4. The distance the driver would have first seen Mr Bancroft was 19.45-22.45m if the driver were not looking for, nor expecting to see a pedestrian. 5. The shortest stopping distance would be 48m an emergency stop. 6. There are no pedestrian facilities on this road.

	There have been three pedestrian fatalities on this stretch of road, all in the early hours, in the dark and whilst the deceased has been drunk. There has also been a non- fatal collision with a pedestrian, again in the early hours.
	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. There is nothing to discourage pedestrians from walking along the A66 eg signage 2. Cars are rapidly accelerating from the well-lit roundabout at Stainburn onto an unlit section of the A66 as the national speed limit sign is very close to the roundabout. 3. The speed of traffic on this initial stretch of the A66 4. The lack of lighting on this initial stretch of the A66
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 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**

8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons , Mr Bancroft's family, 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.
9	**DATE** 16th November 2020. **SIGNED BY CORONER**