MISS KALLY CHEEMA LLB
HER MAJESTY'S SENIOR CORONER
COUNTY OF CUMBRIA

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: CUMBRIA COUNTY COUNCIL (HIGHWAYS DEPARTMENT)**
1	**CORONER** I am Miss Kirsty Gomersal Area Coroner for County 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: https://www.legislation.gov.uk/ukpga/2009/25/contents http://www.legislation.gov.uk/uksi/2013/1629/contents
3	**INVESTIGATION and INQUEST** On 21 May 2018, Ms Kally Cheema (Senior Coroner) commenced an investigation into the death of Michael Andrew HENDERSON to whom I shall refer as Mikey. On 7 June 2018, Mr Robert Chapman (Assistant Coroner) commenced an investigation into the death of Stephen Brian CHAMBERS to whom I shall refer as Stephen. The investigations into Mikey's and Stephen's deaths concluded at the end of their inquests on 28 February 2019. The conclusion of Mikey's inquest was Road Traffic Collision. The medical cause of death of Mikey's death was multiple injuries inconsistent with life. The conclusion of Stephen's inquest was Road Traffic Collision. The medical cause of death of Stephen's death was multiple injuries inconsistent with life.
4	**CIRCUMSTANCES OF THE DEATH** On 1 May 2018 at 21:30, Mikey was the driver of a car in which Stephen was the front seat passenger. It was raining heavily. Mikey was driving in a southerly direction along the A5094 New Road towards Whitehaven. Mikey lost control of the vehicle at speed. The vehicle skidded sideways into a concrete lamp-post. The force of the collision was such that the car was split in two horizontally. Both Mikey and Stephen were declared dead at the scene. Mikey's blood alcohol level was 166 mg per 100 ml of blood. During the course of the inquest, I heard evidence from an experienced Collision Investigator with Cumbria Constabulary. The Collision Investigator could not tell exactly at what speed Mikey's car had hit the lamppost. His opinion was that the car must have travelling greatly in excess of the speed limit of 40 mph. The Collision Investigator advised me that he had never seen a car damaged to the extent that Mikey's car was damaged.

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	The Collision Investigator concluded the collision occurred as a result of, or a combination of, alcohol, excess speed and poorly maintained rear tyres. My findings of fact incorporated the Collision Investigator's conclusions.
5	**<u>CORONER'S CONCERNS</u>** 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: During the course of the inquest, I read evidence from a police constable who attended the scene. He advised me that in his 24 years' service, he was aware of a number of multiple fatal road traffic collisions on this road, mainly involving excess speed. The Collision Investigator gave evidence in person. He has 22 years' police service, the majority of which have been in the roads policing unit. He has been an expert collision investigator since 2011. The Collision Investigator advised me that the speed limit of 40 mph on New Road was appropriate and that relevant signage was appropriate. He was also aware of a number of fatal and serious collisions on New Road. Mikey and Stephen were the third and fourth deaths of which he was personally aware. The Collision Investigator advised me that it is feasible to considerably exceed the speed limit on New Road to 60 or 70 mph or even greater. He advised me that the road has a number of unusual features – it is very wide with embankments and woodland on each side. It is not in a built up area. This may give the impression (despite signage) that the speed limit is much greater than 40 mph. The road travels downhill towards Whitehaven and has a number of bends. The Collision Investigator was concerned that there could be further future deaths on this road because of the speeds that can be attained. His considered opinion was that there were measures that could be taken to reinforce and encourage compliance with the speed limit. I fully appreciate that speed was not the only factor in Mikey's and Stephen's deaths. I also appreciate that it is not possible to "force" drivers to adhere to the speed limit. However, it may be that due to the unusual features of New Road that "traffic calming measures" may reduce the risk of future serious collisions and I recommend that that you give consideration to taking such action.

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6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, Cumbria County Council, has 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 1 May 2019. 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], Mikey's father. [redacted], Mikey's mother. [redacted], Stephen's father. I have also sent it to the following who may find it useful or of interest: Cumbria Constabulary (for the attention of [redacted]). Cumbria Constabulary (for the attention of [redacted]). 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	6 March 2019 Miss Kirsty J Gomersal Area Coroner County of Cumbria

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