



Kally Cheema LLB | Senior Coroner | Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

8 January 2024

REGULATION 28 TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [REDACTED], Chief Executive, National Highways, 3 Ridgeway, Quinton Business Park, Birmingham B32 1AF,

[REDACTED] Area Transport & Highways Manager, Lillyhall Depot, Workington (by email)

1 CORONER

I am Dr Nicholas Shaw, HM Assistant Coroner for Cumbria

2 CORONER'S LEGAL POWERS

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

<http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7>

<http://www.legislation.gov.uk/uksi/2013/1629/part/7/made>

3 INVESTIGATION and INQUEST

On 20 December 2022 I commenced an investigation into the death of Walter FAULDER. The investigation concluded at the end of the inquest. The conclusion of the inquest was Death due to Road Traffic Collision and the medical cause of death was 1a Multiple Injuries

4 CIRCUMSTANCES OF THE DEATH

Walter Faulder BEM was an 88 year old gentleman who lived alone in Wigton, Cumberland. He had recently been discharged from hospital.

On Saturday 10th December 2022, Walter's daughter visited his address and there was a Cranston's shopping bag next to his chair. He said he had got the bus to Orton Grange (where the shop is) and back which raised alarm bells to his daughter. She asked him not to do this journey again as it is unsafe. Walter stated that he believes there is a pelican crossing to assist him crossing the road (A595). This is not the case at Orton Grange.

On Tuesday 13th December 2022, Walter has got the 400 bus at 16:10 hours from Wigton and got off at Orton Grange. Walter has forgotten his wallet and crossed the road to the middle island and continued onto the South-West carriageway. He then collided with a vehicle, causing him to fall into the chevrons in the middle of the road. At the time of the collision it was nearly dark and the road was busy with a steady flow of traffic in both directions moving at normal speed.

Walter was given first aid at scene, however he was pronounced deceased at scene in the rear of the ambulance at 17:20 hours.

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 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) Walter seems to have believed that as a pedestrian he had right of way, he may have been a bit confused having forgotten his wallet however the day before the collision be referred to the illuminated pole in the central refuge as a Belisha Beacon.

(2) I heard that this is a busy crossing point, schoolchildren cross morning and evening for busses too and from school. There are also an increasing number of older people living in nearby developments.

(3) I am concerned that without safety alterations further accidents and possible fatalities may occur. Is there a case for lights to be installed?

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and 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 4th March 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 Walter's daughter

[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 8th January 2024



Signature

Dr Nicholas Shaw

HM Assistant Coroner for Cumbria