	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Bury MBC;** **2. The Secretary of State for Transport (pursuant to paragraph 51 of the Chief Coroner's Guidance Number 5).**
1	**CORONER** I am Peter Sigee, assistant coroner, for the coroner area of Greater Manchester North.
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 2nd April 2016 the senior coroner for the coroner area of Greater Manchester North commenced an investigation into the death of Mr Roger Hamer, aged 83 years. The investigation concluded at the end of the inquest on 11th August 2017. The conclusion of the inquest was that the medical cause of Mr Hamer's death was (1A) traumatic brain injury and (2) multiple fractures. The jury gave a narrative verdict in which they found that Mr Hamer had probably been caused to fall from his bicycle and to suffer the injuries from which he died by a pothole in the carriageway ("the Pothole").
4	**CIRCUMSTANCES OF THE DEATH** On 5th March 2016 Mr Hamer fell from his bicycle on Bury New Road, Ramsbottom, suffering a traumatic brain injury and multiple fractures. He was conveyed to hospital where despite maximal treatment he died from these injuries on 2nd April 2016. Bury MBC is the highway authority responsible for the maintenance of this part of the public highway ("the Highway Authority"). A subsequent police investigation identified 3 potholes in the carriageway near to where Mr Hamer fell. The Pothole was the largest of these defects and on 5th March 2016 the police measured it as being 0.6m wide (at its widest point), 1.5m long and generally in excess of 50mm deep. Google Streetview images confirmed that the location where the Pothole developed was already showing signs of deterioration, wear and cracking in October 2015. The jury accepted the evidence given by a senior police collision investigator and the Highway Authority's group engineer for highway maintenance that this part of the carriageway would have continued to deteriorate until it was repaired.

Bury New Road was subject to a monthly inspection regime by the Highway Authority, and it was inspected on 19th January 2016 and 23rd February 2016. The 23rd February 2016 inspection followed a complaint by a local resident regarding the Pothole which was causing her concern. The highway inspector did not record any details in either of these inspections as to the condition of the carriageway in the location where the Pothole was found and, contrary to the October 2015 images, he asserted that this part of the carriageway was still intact at the date of his last inspection.

On 23rd February 2016 the highway inspector did identify another pothole near to this part of the carriageway and he issued an instruction that it be repaired within 28 days. These repairs would have extended to repair the Pothole. These repairs were not completed until after Mr Hamer had fallen from his bicycle.

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) When he inspected the carriageway in January 2016 and February 2016 the highway inspector did not photograph, measure and/or record any details as to the condition of the carriageway where the Pothole developed despite it having started to deteriorate, wear and crack by October 2015.

This prevented the Highway Authority from effectively assessing the rate of deterioration of this part of the carriageway which may have helped to inform it as to the need for earlier repair.

Also, the lack of images and/or measurements of the Pothole as at the date of the inspections restricted the Highway Authority's ability to effectively supervise and monitor the highway inspector and it hindered the jury's ability to make more detailed findings as to the circumstances of Mr Hamer's death.

(2) The jury recorded its concern as to the lack of paint markings around the potholes which may have highlighted their presence to Mr Hamer thereby enabling him to avoid them.

(3) The Highway Authority does not have a procedure with a duty of candour for the effective investigation of, and learning lessons from, significant incidents comparable to those adopted by other public bodies (for example within the National Health Service).

(4) The Highway Authority is in the process of adopting a new procedure for highway management ("the New Procedure"), apparently based upon ***Well-Managed Highway Infrastructure: a Code of Practice*** published by the Department for Transport in October 2016.

With regards to defects in the carriageway, the Highway Authority's current procedure for highway management has an intervention level of 40mm so that any defect which is found to be 40mm or greater is repaired.

Under the New Procedure 40mm will be redefined as the ***"investigation level"***, so that once a carriageway defect is greater than 40mm a highway inspector will investigate it and consider whether a repair is needed.

	If 40mm is specified in the New Procedure as the minimum threshold for investigation then defects which measure less than 40mm may not be investigated and defects of 40mm or above may not be repaired. Whilst I was informed that highway inspectors have a discretion under both the current and new procedures to repair defects which do not meet the intervention or investigation criteria the jury noted inconsistencies in the application of the current procedure and I consider that the New Procedure will increase the risk of future deaths, in particular to cyclists.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 16th October 2017. 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: the family of Mr Roger Hamer and Mr [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	 **Peter Sigee** Assistant Coroner for Greater Manchester North 21st August 2017