IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Charles Michael Stringer
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • **Chief executive, Surrey County Council** • **Lead for Highways Agency, Surrey County Council** • **Kier Integrated Services Limited**
1	CORONER Dr Karen Henderson, HM Assistant Coroner for Surrey
2	CORONER'S LEGAL POWERS I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	INVESTIGATION and INQUEST On 29th November 2021 I resumed the Inquest touching on the death of Charles Michael Stringer which concluded on 30th November 2021. The medical cause of death given was: 1a. Penetrating injury to the apex of right chest I determined *'Mr Charles Michael Stringer was a very fit man and a proficient cyclist. He developed a punctured tyre on his front wheel of his bike after hitting a pothole, which was awaiting repair, whilst cycling on Church Lane Headley. Following the puncture, he lost control of his bicycle and hit an iron railing at the side of the road. This resulted in a catastrophic chest injury incompatible with survivable and he died at 12.44 hours on 22nd June 2020 in Church Lane, Headley'*. My conclusion was that of an ACCIDENT

4.	CIRCUMSTANCES OF THE DEATH Statutory responsibility for road defect repairs lies with Surrey County Council (SCC) but they contract regular inspections and responses to public complaints and repairs to Keir Customer Services. Church Lane was inspected monthly and was last routinely inspected on the 26th May 2020 when no defects were seen or recorded. On 3rd June 2020 a member of the public informed the Council there was a pothole which was the one responsible for Mr Stringer's accident. An investigator attended the area on 4th June 2020 but failed to find the pothole, making an assumption that a repair on the road some 100m or so away from the pothole was responsible for the complaint. On 6th June 2020 another member of the public reported the same pothole. An investigator attended on 9th June 2020, found the pothole and visually categorised it as a P3 pothole which allocated a maximum of 20 days for it to be repaired. On 11th June 2020 a third concern was raised for the same pothole, but the member of the public was erroneously informed it had been repaired. On 17th June 2020 the same member of the public contacted the council again to say that contrary to what they were told, the pothole had not been repaired. The same investigator attended and noted the pothole had deteriorated in the meantime. He re-categorised the pothole as a P 2 with repair required within five days: no later than 23rd June 2020, which was the day after Mr Stringer died after hitting the pothole.
5	CORONER'S CONCERNS Written submissions from the family and from SCC were requested following the conclusion of the Inquest in relation to PFD matters which has given rise to ongoing concerns: 1. A lack of reflection by SCC following Mr Stringer's death SCC indicated in their written submissions that a senior manager was available to give evidence as to reflection and learning following Mr

	Stringer's death, in the absence of any such evidence in writing or a request to do so during the hearing. 2. A lack of action and/or change to the management of potholes by SCC following Mr Stringer's death SCC has indicated in written submissions that a number of discussions have taken place following Mr Stringer's death but there has been no documented changes in systems or practice in particular: 1. What steps have been taken to ensure inspectors of defects are fully informed of recent complaints including those from members of the public regarding damage to bicycles by the state of the road. 2. What steps have been taken in the provision of a detailed and robust risk assessment by inspectors with all the available information available such as past complaints, the nature of the road and who uses the road to ensure a 'holistic' approach to decision making with regard to the necessity and the speed of road repairs. 3. What, if any, changes have been made to the pictorial guide and the matrix given to inspectors to ensure training there is not an 'overly mechanistic' assessment of a road defect. 4. What steps have been taken to ensure there is appropriate and timely communication between the SCC contact centre and the highways department such as a standard operating procedure in place when complaints must be forwarded on and responded to? 5. What steps have been taken to ensure repairs are completed in a timely fashion after serious injuries and deaths have occurred, as a result of a road defect?
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one have the power to take such action.
7	YOUR RESPONSE

	You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise, you must explain why no action is proposed.
8	COPIES I have sent a copy of this report to the following: 1. See names in paragraph 1 above [redacted] In addition to this report, I am 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.
	Signed: Karen Henderson DATED this 10th Day of October 2022