Lancashire & Blackburn with Darwen Coroners

Regulation 28: REPORT TO PREVENT FUTURE DEATHS (pursuant to Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Lancashire County Council 2. Mr Colledge's Family 3. Chief Coroner
1.	**Coroner** I am Kate Bisset, Area Coroner for Lancashire and Blackburn with Darwen.
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 the 3rd January 2023 the Coroner's Office was notified of the death of Harry College and an investigation commenced into his death. An inquest was opened and adjourned on the 17th January 2023 and a final inquest took place on the 12th and 13th October 2023. The conclusion of the inquest was that: "Harry COLLEDGE died on the 2nd January 2023 at the Royal Preston Hospital as a result of injuries he sustained having been thrown from his bicycle. Mr COLLEDGE was an otherwise fit and healthy man who was a keen cyclist. On the 2nd of January 2023 he was cycling along Island Lane, Winmarleigh when his bicycle entered a crack defect in the carriageway, causing him to be thrown from his bicycle. This defect had been identified to the relevant Council in September 2022 and the subject of highway inspections on the 15th and 26th September 2022, involving six highways team operatives. Despite the Council's notification of the defect and its approximate location, these inspections did not identify the defect which caused Mr COLLEDGE's injuries and thus a dangerous hazard had remained on Island Lane from 9th September 2022 to 2nd January 2023."

4.	**Circumstances of the death** Mr Harry Colledge was a fit and active 84 year old man. On the 2nd January 2023 he was cycling his bicycle with a friend, a common activity for Mr Colledge. He was riding along Island Lane, Winmarleigh when his bicycle entered a crack defect in the carriageway causing him to be thrown from his bicycle and sustain injuries which caused his death. The crack defect in question had been seen by local residents and members of the local Parish Council on the 9th September 2022. They took photographs of the defect and others on the road, and reported them to the Highways department at the Lancashire County Council. The senior manager who received the photographs tasked others to inspect the road and repair the defects. Four Highways operatives attended the road in two vehicles on the 15th of September 2022. The road was driven in its entirety and no defects were noticed or repaired. A second, scheduled inspection took place by Highways inspectors on the 26th of September 2022. This also involved two operatives conducting a driven inspection and neither observed the crack defect which caused Mr Colledge's collision. Consequently the crack was not repaired and remained hazardous in the roadway at the time of Mr Colledge's incident and death.
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. Highway operatives gave evidence that their inspections primarily consider the impact of defects upon cars using that road surface. All gave evidence of no specific training or experience with regards to identifying defects which present a hazard to bicycle users, when expert evidence indicated that the Council's statutory duty required reasonable steps to protect all road users which includes cyclists. The evidence of Council witnesses was unanimous that since Mr Colledge's death, there has been no additional training, updates, briefings or policy reviews to offer further knowledge of operatives in safely assessing defects which pose risks to cyclists or road users other than car drivers. I consider there is a risk of future deaths of all cyclists if Highways Operatives and inspectors are not able to identify defects on a carriageway which present a risk to cyclists as opposed to simply car users. 2. Evidence from a Highways Expert, [redacted], explained that Island Lane is part of peat/moss road which is the subject of natural movement when it rains. The water is absorbed by the peat/moss and swells caused the tarmac to move then it compacts when it dries and the road surface lowers, causing cracks. [redacted]' evidence was that there is natural movement but these defects rarely get better, only worse. I am concerned that the road

	surfacing on Island Lane, Winmarleigh will continue to be the subject of natural movement and the present surfacing is hampered by the geography of the location including camber of the road. I consider there is a risk of future deaths to road users if the surfacing of this road is not adequately maintained. Whilst the inspection schedule timescales enacted by the Council are considered to be appropriate, I consider there is a risk of future deaths due to the present surfacing and underlying geological features of this road if inspections are unable to reasonably identify hazardous defects.
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 the 12th January 2024. I, the Coroner, may extend the period and to take into account the likely disruption to services caused by Christmas breaks, I extend that period of response to the 26th January 2024. 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 Person: The Family of Mr Harry Colledge 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.	**16.11.2023**  **Kate Bisset** **Area Coroner for Lancashire and Blackburn with Darwen**