




## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	<b>REGULATION 28 REPORT TO PREVENT DEATHS</b>  <b>THIS REPORT IS BEING SENT TO:</b>  <b>1 Chief Executive at Surrey County Council</b>
<b>1</b>	<b>CORONER</b>  I am Krestina HAYES, HM Assistant Coroner for Surrey for the coroner area of Surrey
<b>2</b>	<b>CORONER'S LEGAL POWERS</b>  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.
<b>3</b>	<b>INVESTIGATION and INQUEST</b>  On 13 December 2022 I commenced an investigation into the death of John William BASS aged 80. The investigation concluded at the end of the inquest on 30 April 2024. The conclusion of the inquest was that:  Mr John William Bass died of head and chest injuries, at the age of 80 years of age, on A217 Brighton Road Tadworth, following a road traffic collision with a vehicle whilst he was riding his bicycle on 6th December 2022.
<b>4</b>	<b>CIRCUMSTANCES OF THE DEATH</b>  On 6th December 2022 Mr Bass, a fit and active cyclist fell from his bicycle on 6th December 2022 from the pavement on A217 Brighton Road, Tadworth, Southbound into approaching vehicle resulting in head and chest injuries from which he died. My conclusion was Road Traffic Collision.  Surrey County Council is the highway authority responsible for the maintenance of this part of the public highway (the "Highway Authority").  A subsequent police investigation identified the footpath from which Mr Bass fell measured approximately 1.4 meters in width. However, due to the encroachment of mud/grass, twigs and acorns over the pavement space where Mr Bass was able to cycle it only measured 0.6 meters wide.  The Highways Authority confirmed in witness evidence, which was accepted under rule 23, that the A217 Brighton Road, Tadworth is subject to a yearly inspection.  At the inquest the family advised that the footpath is used regularly by cyclists to avoid the vehicles on the busy road, where the speed limit is up to 40mph. This stretch of highway was said to have last been inspected on 14th November 2022 by car. A second scheduled inspection took place by foot on 22nd November 2022, just prior to the accident on 6th December 2022. The inspections did not identify any safety defects meeting the intervention level set out in Surrey County Council's policy. I am informed by the family shortly after the accident the pavement was cleared.
<b>5</b>	<b>CORONER'S CONCERNS</b>  During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the



	<p>circumstances it is my statutory duty to report to you.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows: (brief summary of matters of concern)</p> <p>When the footpath was inspected in November 2022, just weeks before the accident, the highway inspector did not consider the narrowing of pathway as a safety concern and or met an intervention level which required action. It is noted in the policy that there is reference to trees and vegetation, but no clear guidance in terms of vegetation which encroaches on pavements. I am concerned that there is a risk to future pavement users if clear guidance is not provided to inspectors to identify safety concerns regarding vegetation growth on footpaths. The Highways current inspection of the pavement is only yearly albeit in evidence given at inquest by the family, this road is used frequently by cyclists next to a busy road. I am therefore concerned that the frequency of the inspections need to be reviewed.</p>
<b>6</b>	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.</p>
<b>7</b>	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by July 03, 2024. I, the coroner, may extend the period.</p> <p>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.</p>
<b>8</b>	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <p>██████ – son Surrey County Council</p> <p>who may find it useful or of interest.</p> <p>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.</p> <p>I may also send a copy of your response to any person who I believe may find it useful or of interest.</p> <p>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.</p> <p>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.</p>
<b>9</b>	<p><b>Dated: 08/05/2024</b></p> <p></p> <p><b>Krestina HAYES</b> <b>HM Assistant Coroner for Surrey for Surrey</b></p>