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

The Inquests Touching the Death of Lee Michael FRIEND
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: The Secretary of State for Transport (in relation to paragraph 5 (1)) The Chief Constable of Surrey Police (in relation to paragraph 5 (2)) The Chief Executive of Reigate and Banstead Council (in relation to paragraph 5 (3)) The Managing Director of Sutton and East Surrey Water PLC (in relation to paragraph 5 (4))
1	**CORONER** Simon Wickens 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** The inquest into **Lee Michael Friend's** death was opened on the 25th February 2013 was resumed with a jury on 29th of July 2014. The Jury returned their conclusion on the 6th August 2014. The jury found the cause of death was: 1a – Medullary Transection 1b – Fracture of the Cervical Spine The Jury returned a narrative conclusion: On the 21st February 2013 Mr. Friend died as a result of a road traffic collision on the A217 Dovers Green Road. On the balance of probabilities the manner in which the motorcycle was ridden was one of three material contributions to his death. The other material factors that contributed to his death were the positioning of the lights and signs associated with the road works and risk assessments carried out by Sutton and East Surrey Water PLC. were inadequate. Finally, the conduct of Surrey Police following attendance at a road traffic collision on the 20th February 2013

	involving the inadequacy or otherwise of Surrey Police's assessment, response and failure to identify risk to life following the incident on the 20th February 2013.
4	**CIRCUMSTANCES OF THE DEATH** On 20th February 2013 Sutton and East Surrey Water placed road works and a two-way traffic light system beyond what was described as a blind bend. The placing of the lights meant that traffic held by the lights backed up towards the blind bend. A member of the public expressed concerns to the Council that same morning about the proximity of the lights to the bend. That afternoon there was a road traffic collision at the location, which was attended by Police. Despite having concerns over safety to the public the Officer attending did not report these concerns to the relevant authority. The following morning (21st February 2013) there was a similar road traffic collision at the same place. As a result the traffic was stationery just beyond the blind bend. Mr Friend, a motorcyclist travelling at speed, negotiated the bend and collided with one of the stationery cars before being projected into the path of an oncoming car thereby sustaining the injuries from which he died.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed a number matters that gave rise to a concern that circumstances creating a risk of other deaths will continue to exist in the future unless action is taken. The **MATTERS OF CONCERN** are as follows. – 1. Action is required to ensure that when temporary traffic lights are placed there is a minimum distance of visibility (line of sight) between approaching drivers and the temporary traffic light heads. Further, guidance or training should be provided to operatives as to placing traffic lights near to blind bends or where waiting traffic will encroach upon blind bends. 2. Action is required by Surrey Police to formulate a clear policy/protocol for all Officers to follow when they identify a risk created to the public by road works which should include a clear route allow them to locate who is responsible for the placing of the road works if not apologies board is seen/present.

	3. Action is required by Reigate and Banstead Council to ensure that any calls from members of the public to the Council about serious safety issues relating to the road network are passed directly to those with responsibility to take action. 4. Action is required by Sutton and East Surrey Water to take steps to ensure all members of staff are fully and properly trained in the safe setting up of road works and the carrying out of effective risk assessments.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Secretary of State for Transport, the Chief Constable of Surrey Police, the Chief Executive of Reigate and Banstead Council and the Managing Director of Sutton and East Surrey Water 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 Interested Persons in the Inquest and the Chief Coroner.
9	**Signed:** *Simon Wickens* **DATED this 6th day of August 2014.**