



MR G IRVINE
SENIOR CORONER
EAST LONDON

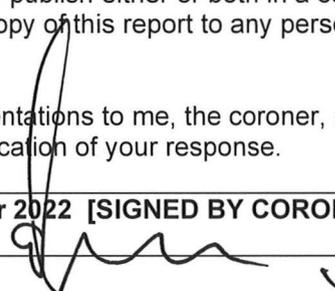
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[REDACTED]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 17666488

| | |
|---|--|
| | <p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. Sir Mark Rowley - The Commissioner for the Metropolitan Police Service [REDACTED]2. Andrew Lord - The Commissioner for Transport for London [REDACTED]3. Mr Sadiq Khan – The Mayor of London [REDACTED]4. The Rt Hon Mark Harper MP - The Secretary of State for Transport [REDACTED]5. The Rt Hon Suella Braverman KC MP – The secretary of state for the Home Department [REDACTED]6. Major Retailers of e-scooters, [REDACTED] [REDACTED] |
| 1 | <p>CORONER</p> <p>I am Graeme Irvine, senior coroner, for the coroner area of East London</p> |
| 2 | <p>CORONER'S LEGAL POWERS</p> <p>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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</p> |
| 3 | <p>INVESTIGATION and INQUEST</p> |

| | |
|---|---|
| | <p>On 22nd March 2022 this Court commenced an investigation into the death of Fatima Abukar age 14 years. The investigation concluded at the end of the inquest on 13th December 2022. I arrived at a short form conclusion of Road Traffic Collision.</p> <p>Ms Abukar's medical cause of death was determined as;</p> <p>1a Head Injury 1b Blunt Force Trauma (Road Traffic Collision)</p> |
| 4 | <p>CIRCUMSTANCES OF THE DEATH</p> <p>Fatima Abukar was a 14 year old girl who died due to catastrophic head injuries sustained in a road traffic collision.</p> <p>Ms Abukar was observed to ride a battery-powered e-scooter in a southerly direction on the west pavement of Green Street, East Ham. Ms Abukar was travelling at a speed not less than 11 mph, she not wearing any safety equipment.</p> <p>Ms Abukar left the pavement and entered the northbound carriageway of the road, against the flow of traffic. Ms Abukar bore left, over the central markings of the road and joined the southbound carriageway travelling alongside a mini-bus.</p> <p>The e-scooter struck the off-side of the mini-bus, Ms Abukar lost control and fell beneath the wheels of the mini-bus.</p> |
| 5 | <p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none"> 1. Evidence in this inquest confirmed that since 2019 there have been 8 recorded fatalities involving e-scooters in London and 31 in the country at large. At the time of her death Ms Abukar was riding a privately owned e-scooter on a public highway. Despite the ubiquity of such devices on London's streets, riding them on public roads is unlawful. <p>Whereas approximately 4000 unlawfully used scooters were seized by the Metropolitan Police Service in 2021, only 1100 were confiscated in 2022. The reduction is attributable to a change in policy introduced in November 2021.</p> <p>An inverse correlation exists between the rate of legal enforcement and the rate of deaths caused by e-scooters. The number of deaths in Q1 & 2 of 2022 is more than double that of Q1 & 2 of 2021.</p> <ol style="list-style-type: none"> 2. Ms Abukar died due to traumatic head injuries. Riders of legally authorised scooters (those hired from licenced operators) are not required to wear head protection. 3. Some manufacturers and retailers of e-scooters in England and Wales provide consumers with written warnings about the illegal use of e-scooters, others do not. Where such warnings are present, often they are not prominent. |
| 6 | <p>ACTION SHOULD BE TAKEN</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> |

| | |
|---|---|
| 7 | <p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 8TH February 2023 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> |
| 8 | <p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons the family of Fatima Abukar, and to the local CDOP (where the deceased was under 18)].</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 other 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.</p> |
| 9 | <p>[DATE] 14th December 2022 [SIGNED BY CORONER]</p>  |