REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Stockport Metropolitan Borough Council, Highways Department Secretary of State for Transport
1	**CORONER** Christopher Murray HM Assistant Coroner Manchester South Coronial Area Mount Tabor Stockport
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 29th August 2023 an inquest was opened into the death of Scott Bradley Davies aged 32. The inquest concluded on 19th September 2024. I made a determination at inquest that Scott Bradley Davies died as a result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** Scott Davies had collected his modified Sur-Ron Light Bee Motorcycle on the evening of Friday 2nd February 2024 and returned home carrying the unregistered motorcycle in a van. He proceeded to attend upon Alexandra Park in Stockport to test out the vehicle. He collided with a steel barrier which was in a closed position. He was dismounted from the vehicle and sustained serious head injuries. He was not wearing a helmet at the time of his collision. He was given first aid at the scene and taken to Salford Royal Hospital by ambulance. He was treated by way of sedation and ventilation but never regained consciousness and died as a result of a traumatic brain injury on 8th March 2024 at Salford Royal Hospital.

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 - The section of road bisecting Alexandra Park, known as Cheadle Old Road Edgeley, is a legitimate right of way for bicycles and emergency services vehicles yet there is a matt black locked steel barrier that is hard to see at dusk and in the dark which could result in serious injury or death if struck by an oncoming legitimate user of that thoroughfare.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and/or your organisation 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 **26th November 2024**. I, the coroner, may extend the period. 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 following Scott's family. HHJ Alexia Durran, the Chief Coroner of England & Wales The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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.
9	**DATE** 1st October 2024 Signed *C S Murray* HM Assistant Coroner