	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. THE CHIEF EXECUTIVE, NATIONAL HIGHWAYS**
1	**CORONER** I am Adrian Farrow, Hm Assistant Coroner, for the coroner area of Greater Manchester South
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 15th August 2024 an investigation was commenced into the death of Alexander Charles Edward Thomas, aged 42. The investigation concluded at the end of the inquest on 13th January 2025. The conclusion of the inquest was that he **died from multiple injuries consistent with a road traffic collision when he committed suicide.**
4	**CIRCUMSTANCES OF THE DEATH** Mr Thomas died on 14th August 2024 when he entered the eastbound carriageway of the M56 motorway between junctions [redacted]. A heavy goods vehicle collided with him when he deliberately stood in its path and he sustained fatal injuries. He had a longstanding diagnosis of depressive disorder. The location of the collision was close to where [redacted] passes under the M56 motorway and the nearby premises and car parks of the [redacted] and the evidence was that Mr Thomas had entered the motorway from the [redacted] area.
5	**<u>CORONER'S CONCERNS</u>** 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. The **MATTERS OF CONCERN** are as follows. – 1. During the inquest, I heard that [redacted] is a pedestrian walkway running underneath the M56 motorway. On the northern side of the motorway (eastbound carriageway side) the entrance to the walkway tunnel is constructed so that the buttress walls form a ramp-like structure which has a shallow gradient topped with a waist-high railing which provides an easily accessible and walkable route from the footpath to the Armco crash barrier bordering the hard shoulder of the eastbound motorway carriageway. 2. Also leading from [redacted] is an established track through undergrowth running west parallel to the motorway. That path leads directly to a fixed bespoke metal ladder which appears to be specifically positioned so as to enable a person to climb up to the Armco crash barrier bordering the hard shoulder of the eastbound carriageway. 3. There is no fencing to prevent access over the Armco crash barrier onto the motorway itself along this stretch of the eastbound carriageway, in contrast to the substantial fencing positioned behind the Armco crash barrier along the opposite stretch of the westbound carriageway.

	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 13th March 2025. 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 Chief Coroner and to the following Interested Person Mr Thomas' brother on behalf of Mr Thomas' family. I have also sent it to Chief Superintendent, Greater Manchester Police Roads Policing Unit, who may find it useful or of interest. 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	**Adrian Farrow** **HM Assistant Coroner**  **16th January 2025**