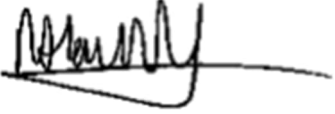




## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>1. Secretary of State for Transport</b></p>
1	<p><b>CORONER</b></p> <p>I am Nathanael Hartley, assistant coroner for the coroner area of Nottingham and Nottinghamshire.</p>
2	<p><b>CORONER'S LEGAL POWERS</b></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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 16<sup>th</sup> October 2024 an inquest was opened into the death of Daniel Isaacs, aged 41. The inquest concluded on 16<sup>th</sup> December 2024. I made a determination at inquest that he died as a result of a road traffic collision.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Daniel Isaacs was travelling along Carlton Road, Nottingham, when he lost control of his electric scooter. He was dismounted from the vehicle and collided with the road surface causing a serious head injury. He was not wearing a helmet at the time of his collision. He received first aid and treatment at hospital but died as a result of the head injury on 24<sup>th</sup> May 2024 at the Queen's Medical Centre in Nottingham.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></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> <p>There is no requirement that riders of electric scooters wear helmets. Due to the expectation of their use on the road, and their vulnerability, there is a risk of death to riders of electric scooters and bicycles not wearing protective headwear who are involved in collisions, even at lower speeds.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>

7	<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 18 February, 2025. 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><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> <ol style="list-style-type: none"> <li>1. Daniel's family.</li> </ol> <p>I have sent a copy of the report and the response to the Nottinghamshire Police Serious Collision Investigation Unit as I believe they may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response and all interested persons who, in my opinion, should receive it. 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. 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 by the Chief Coroner.</p>
9	<p><b>Dated: 24 December 2024</b></p>  <p><b>Nathanael Hartley HM Assistant Coroner For Nottingham and Nottinghamshire</b></p>