GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW

Telephone: [redacted]
Email: [redacted]

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Secretary of State for Transport** **Welsh Government Cabinet Secretary for Transport**
1	**CORONER** I am Gavin Knox Assistant Coroner for the coroner area of South Wales Central.
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 8 November 2022 I commenced an investigation into the death of Ian Augustus JONES . The investigation concluded at the end of the inquest 07/02/2025 . The conclusion of the inquest was Accidental Death. **1a Traumatic Brain Injury**
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- Mr Ian Augustus Jones died at University Hospital Wales, Cardiff on 29 October 2022 as a result of a traumatic brain injury sustained having struck his head on the pavement after he

	collided an electrically motorised bicycle, which he was riding without a helmet, with a bollard on the pavement on Caerphilly Road Cardiff. .
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 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. (1) The accessibility of electric motors and parts that can be easily used to convert a normal pedal bicycle into a high powered, throttle controlled scooter capable of high speeds with rapid acceleration that can pose a danger to the rider and to other members of the public.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 4 April 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 family 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	7 February 2025 **SIGNED:**

Gavin Knox, Assistant Coroner for South Wales Central Coroner Area

Coroner’s Office, The Old Courthouse, Courthouse Street, Pontypridd, CF37 1JW

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