REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Timothy William BRENNAND, Senior Coroner, for the coroner area of Manchester West.
2.	**DATE OF REPORT** 14 September 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. National Highways 2. Department for Transport You are under a duty to respond to this report within 56 days of the date of this report, namely by November 09, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

6.	**SUMMARY OF CORONER'S CONCERN** The case concerns the [redacted] that had been temporarily sited on a section of the M60 motorway, [redacted], Greater Manchester – to signify to maintenance workers where areas of repair were required. [redacted] This was the second such incident in ten days at this approximate location.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 9th April I commence an investigation into the death of Kieran WALSH aged 64. The investigation concluded at the end of the inquest on 20th August 2026. On the 8th of April 2026, the deceased parked his car on the inside lane of the M60 motorway at [redacted] Greater Manchester. Although unwitnessed, it is likely that he [redacted] and jump to he death having sustained immediate, fatal blunt force traumatic injuries on impact. The conclusion of the inquest was Suicide.
9.	**CIRCUMSTANCES OF DEATH** On the 7th of April 2026, the deceased self-presented at the North Manchester General Hospital with superficial injures to his wrists that he had recently and deliberately self-inflicted in the context of a newly prevailing phase of low mood, anxiety and emotional dysregulation associated with his personal circumstances. There was no prior mental health diagnosis or any history of self-harming ideation. He was assessed by a Mental Health Liaison Team who considered him to be at low ongoing risk of self-harm, with no acute mental health condition being evaluated on a differential basis. He was discharged home with advice and referral to his general practitioner. He re-presented at the same hospital two hours later, having just purchased a [redacted] which he stated to have consumed with recurrent self-harming ideation. He was further assessed by the same Senior Urgent Care Navigator/Gatekeeper (a mental health nurse) who, having discussed with the deceased his current thoughts and feelings considered that he still did not

	appear to be at real or immediate risk of self-harm, and so discharged him again on the same pathway of conservative, community based mental health management and care on the basis she did not assess the deceased to meet the threshold for Community/Crisis or Home Based Treatment Team input. The deceased returned home that afternoon in a taxi driven by an acquaintance to whom he made concerning remarks about his actions. At 6.04am on the 8th of April 2026, the deceased parked his car at the side of the carriageway on the M60 motorway on [redacted] Despite the installation of tall parapets and anti-climbing mesh along the side of the road, it is likely that the deceased was able to make use of [redacted] and thereafter jump from the bridge. Emergency services discovered the body of the deceased on ground beneath the bridge having sustained catastrophic and immediately fatal injuries. Whilst no note or other direct evidence of intent was discovered, the actions of the deceased were both deliberate and intentional, albeit in the context of his thoughts and feelings being overborne by irrational, illogical, impulsive and dysfunctional emotional dysregulation associated with his current relapse into mental ill health and recently impaired judgment and capacity.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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. The use of tall traffic cones to mark areas of damage [redacted]. 2. This was the second death in the same proximate location with a fortnight – suggesting that the anticlimbing meshing and infrastructure may be insufficient to deter people wishing to jump for the bridge. 3. The incident were unwitnessed, there was no evidence to suggest that any CCTV cameras cover the bridge to assist real time suicide surveillance.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to:

	• Family of the deceased • Greater Manchester Police Road Policing Unit • National Highways Traffic Officers - Manchester I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE**  **Timothy William BRENNAND** **Senior Coroner for** **Manchester West**