REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive, Stockport Metropolitan Borough Council.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 3rd August 2015 I commenced an investigation into the death of Aleeza Ahmed dob 2nd March 2009. The investigation concluded on the 25th January 2016 and the conclusion was one of **Accidental Death**. The medical cause of death was 1a Head Injury.
4	**CIRCUMSTANCES OF THE DEATH** **Aleeza was being carried in the car being driven by her father. She was not restrained by a child seat or seat belt. The car left the carriageway and she was thrown from the vehicle and received severe head injuries.**
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. – 1. **This incident occurred at Crookilley Way, Stockport on the 26th July 2015. The vehicle had exited the M60 (clockwise section) at junction 25. As it left the roundabout on to Crookilley Way, the driver lost control and the vehicle mounted the offside kerb, crossed the central reservation and overturned throwing the child from the car as this happened. The kerb stones to the offside of the carriageway are of a chamfered design and it would appear that this may have contributed to the vehicle overturning. Questions were raised as to whether these kerbs should be replaced with a more traditional 90 degree type.** 2. **There would appear to be no protective Armco type barrier on the central reservation at this point. The evidence suggested that had such been present the trajectory of the vehicle might have been different and less danger caused to all road users.**
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you 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 **29th April 2016**. 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 Persons namely [redacted] (father of the deceased). I have also sent it to **The Road Policing Unit, Greater Manchester Police** and to **The Highways Agency** 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	**3.3.16** **John Pollard, HM Senior Coroner**