

H M Assistant Coroner for Gloucestershire Dr Simon Fox QC

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Local Highways Manager Gloucestershire county Council Floor 5 Block 5 Shire Hall Westgate Street Gloucester GL1 2TG CORONER Lam Caroline Saunders, H.M. Assistant Coroner for Gloucestershire. CORONER'S LEGAL POWERS 2 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 14th December 2018 I commenced an investigation into the death of **Ahmed Hassam Motala** The investigation concluded at the end of the inquest on 21st May 2019 The conclusion of the inquest was: Road Traffic Collision. 1a) Multiple Injuries The medical cause of death was CIRCUMSTANCES OF THE DEATH On 29th November 2018, Ahmed Motala was cycling to work along the A38 at Cole Avenue in Gloucester. He was cycling in a westbound direction in cycle lane. After the junction with Epney Road, Mr Motala was in collision with a lorry. It appears that Mr Motala swerved or was blown by the wind into the lorry. The injuries he sustained resulted in his death. **CORONER'S CONCERNS** 5 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. -The evidence of the Police Collision Investigator and the evidence of witnesses who were motorists on the day (one who regularly used the cycle lane himself) describe the state of the cycle lane as being in very poor condition and cyclists have to swerve in the cycle lane to avoid the defects. Moreover I heard that to avoid the defects they cycle very close to the while line separating the lane with the traffic. This is obviously very dangerous. At the time of the impact, Mr Motala was not in a cycle lane, what is more the weather on that day was described as "diabolical". Therefore I do not consider that the state of the cycle lane itself contributed to his death. However, I am concerned that lives of cyclists in the future may be put at risk if the cycle lane

stays in the current state of repair.

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 4pm 19 th July 2019.
	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 (1) The family of Mr Motala (2) (3)
	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	Dated 24/5/19
	SignatureClouds
	Caroline Saunders H M Assistant Coroner for Gloucestershire