## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:** Greater Manchester Combined Authority, the Home Office |
| 1 | CORONER<br><br>I am, Alison Mutch Senior Coroner, for the Coroner Area of South Manchester |
| 2 | CORONER'S LEGAL POWERS<br><br>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<br><br>On 5th June 2018, I commenced an investigation into the death of Sophie Louise Lyons. The investigation concluded on the 16th May 2019 and the conclusion of the jury was one of;<br><br>**Narrative: Sophie died as a result of being struck by a car driven by an uninsured, unlicensed person, whilst he was performing a dangerous manoeuvre at an illegal car cruising event on a public highway where a Public Spaces Protection Order was in place.**<br><br>The medical cause of death was **1a) Traumatic Brain/Head Injury** |
| 4 | CIRCUMSTANCES OF THE DEATH<br>Sophie died as a result of a traumatic brain injury sustained during a high impact collision with a car whilst attending a car cruising event on 31st May 2018 at Europa Circle in Trafford Park. Car cruising events are illegal gatherings of car enthusiasts where people discuss cars, meet friends and in some cases carry out dangerous driving manoeuvres including speeding, racing and drifting. Drifting is inducing a deliberate loss of control.<br><br>It was during one such manoeuvre that Sophie was struck. The driver was unlicensed and uninsured.<br><br>Sophie subsequently died in Salford Royal Hospital on 1st June 2018 as a result of a catastrophic injury. |

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| | The contributing circumstances were that, although individuals representing Greater Manchester Police and the local authority acted with good intentions to tackle car cruising, the joint partnership approach did not work.<br><br>Even though car cruising had been identified as an issue as early as 2014 in the area, the measures and plans in place to tackle it were ineffective at the time of Sophie's death.<br><br>In addition, limited resources, complex logistics, bureaucracy and poor communication all contributed to an ineffective and slow response to preventing the circumstances surrounding Sophie's death. |
| 5 | <u>CORONER'S CONCERNS</u><br><br>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.<br><br>The MATTERS OF CONCERN are as follows. –<br>The inquest heard that car cruising had been an issue in Trafford Park for a number of years. The problem (and inherent risk to public safety) was one that both the Local Authority (Trafford MBC) and GMP were aware of.<br>Attempts to tackle it had been ineffective. Car cruising involved highly dangerous manoeuvres being carried out on public roads whilst members of the public were using the roads in significant numbers. The inquest saw video footage that showed the events leading up to the death of Sophie. It was clear that an incident involving disastrous loss of control could have happened at any time that night whilst car cruising was taking place. In addition, the inquest heard that whilst on this occasion Sophie was the sole fatality it could easily have been the case that multiple lives were lost in the incident.<br><br>One measure taken involved an application for a Public Spaces Protection Order. This had been a joint initiative but the implementation of enforcement meant that it was not effect.<br><br>The inquest heard that to tackle car cruising successfully, an effective multi-agency adequately funded and targeted approach was required. In addition the inquest heard that in an area such as Greater Manchester with multiple Local Authorities and dense population, a pan Greater Manchester approach would be required to prevent not just further incidents in Trafford Park but across Greater Manchester and nationally. The risk being that looking at the problem of car cruising in isolation could result in it being moved on rather than being dealt with effectively. |
| 6 | ACTION SHOULD BE TAKEN<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |

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| 7 | YOUR RESPONSE<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th August 2019. I, the coroner, may extend the period.<br><br>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<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely 1) Sophie's family 2) Greater Manchester Police 3)Trafford Council, who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **Alison Mutch OBE**<br>**HM Senior Coroner**<br>**19/06/2019** |