Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Tony Reeves, Chief Executive of Liverpool City Council
2 Merseyside Police
[redacted]

1 CORONER

I am Anita BHARDWAJ, Area Coroner for the area of Liverpool and Wirral

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 30/08/2019 I commenced an investigation into the death of Grant Alexander Macdonald aged 27. The investigation concluded at the end of the inquest on 15 June 2020. The conclusion of the inquest was:

I a Multiple Trauma

I b Road Traffic Collision

I c

II

4 CIRCUMSTANCES OF THE DEATH

Grant Alexander Macdonald was a 27 year old gentleman who, on 19 August 2019, was riding a Honda CBR600 motorcycle, on Hornby Road, Liverpool, Walton, Liverpool, near to the HMP Liverpool, in the direction of Rice Lane when he collided with the rear offside area of a Mercedes CLK200, which had pulled out of the Prison carpark and was stationary or slow moving, waiting to turn right in a gap in the central reservation of the road and perform a U-turn in order to travel on the opposite side of the carriageway towards Southport Road. As a result of the collision, Grant suffered significant injuries and died the same day. In this case there were a number of contributory factors to the collision, including the manner in which the motorcycle was being driven and the speed at which it had been driven, however, issues were raised at the inquest by the family and Merseyside Police suggestive of the fact that the junction is unsafe and that there have been a number of collisions at that junction.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

In this case there were a number of contributory factors to the collision, including the manner in which the motorcycle was being driven and the speed at which it had been driven, however, issues were raised at the inquest by the family and Merseyside Police suggestive of the fact that the junction is unsafe and that there have been a number of collisions at that junction. There is concern it is unsafe for a car to go across the carriageway to the central reservation to carry out a u turn manoeuvre. The Court would request the Council to review the safety of this junction.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 10 August 2020. 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

[redacted]
3 Liverpool City Council
4 Merseyside Police

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.

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Anita BHARDWAJ
Area Coroner for
Liverpool and Wirral
Dated: 15 June 2020