ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] – Head of Highways at RCTCBC** **2. Chief Coroner**
1	**CORONER** I am Graeme Hughes, Assistant Coroner, for the coroner area of Powys, Bridgend and Glamorgan Valleys
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 6th September 2013 I commenced an investigation into the death of Stephen John Owens age 42. The investigation concluded at the end of the inquest on 14th May 2014. The conclusion of the inquest was a road traffic collision and the medical cause of death was 1a.Massive Haemorrhage, 1b. Complicated Open Fracture of Right Tibia and Fibula, Rib Fractures and Left Lower Lobe Lung Contusion.
4	**CIRCUMSTANCES OF THE DEATH** Mr Owens was fatally injured in a running down accident which occurred in the south bound carriageway of the Ely Valley Road, Coed Ely at approximately 21:35 hrs on the 29th August 2013.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Street lamp number 19 situated on the pavement to the north bound carriageway of the Ely Valley Road was unilluminated at the time of the collision. (2) Street lamp number 18 again on the pavement adjacent to the north bound carriageway of the Ely Valley Road was obscured by overhanging foliage. (3) Consequent upon (1) and (2) the level of illumination in the proximity of the collision was likely to have had an effect upon the ability of the driver to see the deceased ahead of him on the south bound carriageway.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 14th July 2014. 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 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	**19th May 2014** **SIGNED:**