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. Powys Highways Department** **2. Chief Coroner** **3. Family –** [redacted]
1	**CORONER** I am Andrew Barkley, Senior 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 the 13th May 2014 I commenced an investigation into the death of Alan Derek Evans. The investigation concluded at the end of the inquest on the 23rd October 2014. The conclusion of the inquest was Accidental death.
4	**CIRCUMSTANCES OF THE DEATH** On the 4th May 2014 the deceased was riding his Honda Fireblade motorcycle travelling on the A489 between Newtown and Kerry heading towards Kerry when at approximately 11:50 he overtakes a vehicle prior to a left hand bend. On returning to his lane he loses control of his vehicle and veers into the "wrong lane" and his hit by an oncoming vehicle before being run over by one travelling immediately behind the first. He was declared deceased at the scene.
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) The road at this particular location is governed by a single broken white line indicating that overtaking is permitted. Given the layout of the road, the existence of a side entrance to it, the impact of hedges obscuring the view of the road consideration, in my opinion, ought to be given to putting double white line markings on this particular stretch of road. (2) The evidence suggested that one of the most likely causes of the deceased losing control of his motorcycle was contact with a protruding cats eye. This was agreed by the senior investigation officer and the collision investigation officer who both held the view

	that this may have contributed to the accident. Consideration in my view ought to be given to replacing the "old style cats eyes" with the newer "slim line" version to minimise this risk in the future should it not be considered appropriate to make the area subject to double white lines to prohibit overtaking.
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 25th December 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, Powys Highways Department, [redacted] Collision Investigating Officer with Dyfed Powys Police and [redacted] Senior Investigating Officer with Dyfed Powys Police Collision Investigation Unit and [redacted] 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	**29th October 2014** **SIGNED:** **Mr Andrew Barkley** **HM Senior Coroner**