REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive of the City & County of Swansea** 2. **Leader of the City & County of Swansea** 3. **Head of Legal Democratic Services & Procurement of the City & County of Swansea**
1	**CORONER** I am Colin Phillips, acting Senior Coroner, for the coroner area of Swansea Neath & Port Talbot
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** On 2nd October 2013 the Senior Coroner commenced an investigation into the death of Daniel Hannen Foss aged 37 years. The investigation has not yet concluded and the inquest has not yet been heard.
4	**CIRCUMSTANCES OF THE DEATH** A collision occurred at a pedestrian crossing on the Kingsway Swansea at approximately 16.50 hrs on Tuesday 24 September 2013 when Mr Foss stepped from the central reservation into the path of a Single Decker Coach without looking in the direction from which the coach was coming.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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:- Since 1st January 2008 there have been in excess of 100 reported road traffic collisions and incidents on the Kingsway/Metro system which in a large number of cases included incidents of injuries or near misses between pedestrians and coaches. There have been 2 fatalities including Mr Foss and most recently the death of Sgt Louise Lucas. There would appear to be a serious design issue which must be addressed by the Local Authority to make the road safer for the public.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 3 June 2015. 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. 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	 **08.04.2015** **SIGNED BY ACTING SENIOR CORONER**