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. **Chief Coroner** 2. **Highways Authority – Powys County Council** 3. **Families –** [redacted]
1	**CORONER** I am Andrew Barkley, Senior Coroner, for the coroner area of South Wales Central.
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** The investigation started on the 12th March 2015 into the death of: Rhodri Dafydd Miller-Binding, Margaret Elizabeth Challis, Alesha Marie O'Connor, Corey Bailey Price. Concluding at the end of an inquest which was 12th April 2016 the conclusion of the inquest was that a Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** Just after 10 o' clock in the evening on Friday 6th March 2015 Rhodri Dafydd Miller-Binding was heading north on the A470 close to the Storey Arms, Brecon when on a left hand bend in the road he lost control of his vehicle crossing the carriageway and hitting a vehicle travelling in the opposite direction. He and Corey Bailey Price, a rear seat passenger in his vehicle were declared deceased at the scene and Alesha Marie O'Connor, his front seat passenger and girlfriend was conveyed to the Prince Charles Hospital where she died of her injuries a short time later. Margaret Elizabeth Challis, the front seat passenger in the vehicle being driven in the opposite direction suffered extensive injuries and passed away at the Prince Charles Hospital a short while later.
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. – 1) The stretch of road along the A470 is subject to a 60 mile per hour speed limit but is known to be particularly "challenging" stretch of road on which there have been many serious injury and fatality collisions in the past. The evidence at the inquest from the Forensic Collision Investigating Officer was clear in that an advanced warning sign of an approaching left bend would be of significant assistance in warning motorists of the nature of the road ahead and thereby reducing the risk of a similar fatality.

	Whilst there was evidence at the inquest to support the view that Rhodri Milling-Binding's vehicle was being driven at an inappropriate speed, it was not felt that any form of speed restriction was appropriate at this location – simply an advanced warning sign of the nature of the road ahead.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 June 2016. 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, the family/next of kin and the Highways Authority at Powys County Council. 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 April 2016** **SIGNED:** **HM Senior Coroner**