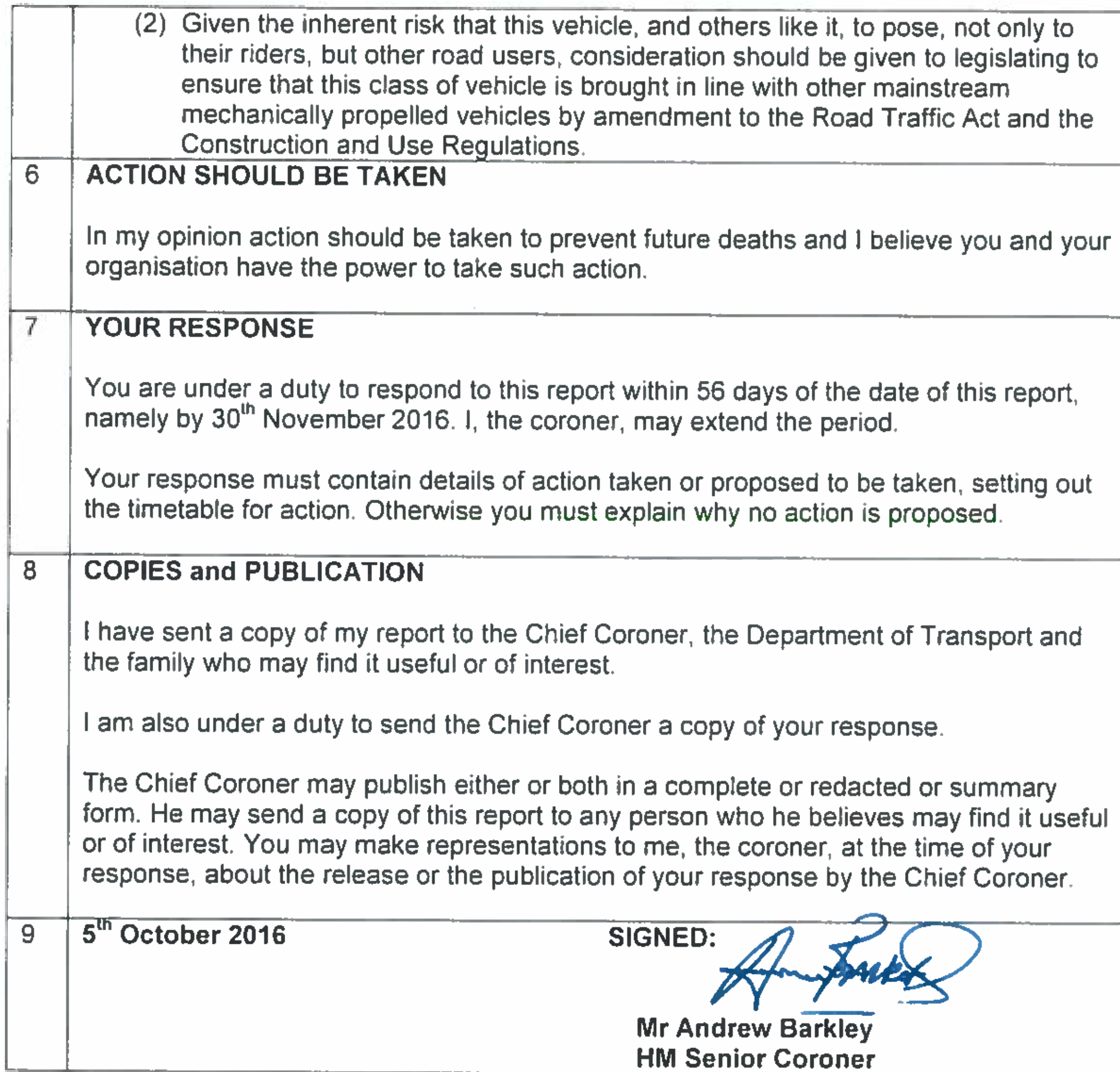
ANNEX A

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. **NOK** 3. **Department of Transport**
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** On the 14th July 2016 I commenced an investigation into the death of Colin George Wellings. The investigation concluded at the end of the inquest on the 23rd September 2016. The conclusion of the inquest was Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was riding his three wheeled motorised trike, which was a domestically constructed machine fitted with a 3.5 litre engine, along Plantation Lane, Newtown, Powys outside the Newtown High School around 2pm on Friday 8th July 2016. On the approach to and entering a mini island, he lost control of the machine and was thrown clear of it, sustaining serious head and other injuries from which he died at the scene. He was not wearing a helmet or seat belt as there was no requirement under the current law for either to be worn on the machine. The vehicle, when examined after the collision, was found to have a defective throttle which on balance, is likely to have contributed to his speed as he entered the roundabout.
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 machine that the deceased was riding was a domestically manufactured machine with a 3.5 litre engine registered in 1973 and as such was exempt from the requirement for the driver/rider to wear either a seatbelt or a protective helmet.



	(2) Given the inherent risk that this vehicle, and others like it, to pose, not only to their riders, but other road users, consideration should be given to legislating to ensure that this class of vehicle is brought in line with other mainstream mechanically propelled vehicles by amendment to the Road Traffic Act and the Construction and Use Regulations.
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 30th November 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 Department of Transport and the family 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	**5th October 2016** **SIGNED:** **Mr Andrew Barkley** **HM Senior Coroner**