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. **Chairman of the Board of Governors at the Maesteg Comprehensive School** 2. **Head teacher** 3. **Chief Executive of the Bridgend County Borough Council**
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 18th December 2014 I commenced an investigation into the death of Ashley Daniel Talbot aged 15. The investigation concluded at the end of an inquest held at the Aberdare Coroners Court between Monday 13th February 2017 through to Thursday 16th February 2017. The conclusion of the inquest was "Accidental Death".
4	**CIRCUMSTANCES OF THE DEATH** The deceased was a pupil at the Maesteg Comprehensive school and shortly after 3pm on the 10th December 2014 was running with a fellow pupil to catch his bus home when he was struck by a school minibus being driven in the school grounds as he entered the carriageway from between 2 parked buses. He suffered extensive injuries to his head and chest and was confirmed deceased at the scene.
5	**CORONER'S CONCERNS** During the course of the inquest, and the investigation leading up to it, the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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 evidence revealed clear deficiencies in relation to the design of the "service road" leading up to the school. This included the construction of a "bus bay" which was inadequate for the number of vehicles required to transport children from the school at the end of the school day. As a direct result of this buses were parked outside the designated bus bay on the other side of the road

	necessitating children to cross the road which was, at the time of the accident, being used by other vehicles such as staff vehicles, visitors vehicles and school vehicles. This created a highly dangerous situation which resulted in the loss of life. The evidence also revealed that there had been several "near misses" which appeared to have gone unreported. (2) At the time of the accident there was insufficient staff supervision of children boarding buses at the end of the school day. Given the issues with the site, which the evidence indicated had been raised when the school was still under construction and before it opened in 2008, the number and position of staff was inadequate to ensure children boarded their buses safely. (3) The wider investigation revealed that there was a clear lack of accountability between the various stakeholders in the design and construction of the school premises to ensure that a safe facility was constructed. Appropriate Safety Advice at an early stage, the evidence showed, would have reduced the likelihood of injury or death.
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 19th April 2017. 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 Welsh Assembly Government 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	**22nd February 2017** **SIGNED:** **Mr Andrew Barkley** **HM Senior Coroner**