Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
The state of the s	THIS REPORT IS BEING SENT TO:
	1. County Council Newport
1	CORONER
	I am Caroline Saunders, Senior Coroner for the Area of Gwent
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 30 th April 2018, I commenced an investigation into the death of Gareth John Williams , DOB : 7/3/1958
	The investigation concluded at the end of the inquest on 20/11/2019
	The conclusion of the inquest was recorded as Road traffic Collision
	The medical cause of death was 1a) Multiple injuries 1b) Trauma
4	CIRCUMSTANCES OF THE DEATH
	Gareth John Williams died at 08.30 on 19th April 2018 from the injuries he sustained when his motorbike was in collision with a car on A468 near Machen.
5	CORONER'S CONCERNS
	During the course of the inquest, 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: -
	Gareth John Williams died when the motorcycle he was riding was in a collision with a BMW. He was travelling along the A468 in the direction of Newport and overtaking a

the driver of the BMW was turning out of the junction line of traffic. which leads to Lower Ocherwyth. This area of road is known as the Machen mile, or Mad Mile and anecdotally I heard that it is a straight length of road where motorists are inclined to drive at speed. I determined that Mr Williams was travelling in excess of the speed limit and his overtaking a number of vehicles along this road contributed to the collision I consider, having taken evidence from the collision Investigator, that safety along this stretch of road would be improved if consideration was given to extending the range of double white lines to this area of the A468 to restrict overtaking. 6 **ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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. I, the Coroner, may extend this 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 necessary 8 **COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) Family of Mr Williams Insurers of Mr Williams Insurers of 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 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. 25/11/19 9 Signed Caroline Saunders Senior Coroner for the Area of Gwent.